1-1-1985

Ideological biases in clinical judgment.

John D. Gartner
University of Massachusetts Amherst

IDEOLOGICAL BIASES IN CLINICAL JUDGMENT

A Dissertation Presented

By

JOHN DOUGLAS GARTNER

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

September 1985

Department of Psychology

IDEOLOGICAL BIASES IN CLINICAL JUDGMENT

A Dissertation Presented

By

JOHN DOUGLAS GARTNER

Approved as to style and content by:

Morton Hamatz, Ph.D., Chairperson of Committee

Castellano Turner, Ph.D., Member

Ronnie Janoff-Bulman, Ph.D., Member

Wade Clark Roof, Ph.D., Member

Seymour M. Berger Ph.D., Department Head
Department of Psychology

To Alison

ACKNOWLEDGEMENTS

I would like to thank all of the people whose encouragement and direction have helped me to become a doctor. In particular, I would like to thank Mort Harmatz whose always gentle guidance has been an important factor in my increasing scholarly maturity over the last two years, as well as the rest of my committee, Cass Turner, Ronnie Janoff-Bulman, and Clark Roof. I am also in debt to Trina Hosmer, Eva Cohen, and the "consulting office gang" who put up with and helped me while I lived in the computer center this summer. I also must thank my wife, with whom I have come to share more and more professionally and personally. Finally, thank you to my parents and grandparents, my best friend, Harry Segal, my Creator, and twenty-two years' worth of teachers, without whom I wouldn't know how to read this, much less write it.

TABLE OF CONTENTS

APPENDIX

LIST OF TABLES

Table

LIST OF FIGURES

Figure

CHAPTER I

INTRODUCTION

Psychology and Religious Bias

In the last half century, psychologists and other social scientists have played a leading role in our culture's efforts to curb prejudice. Long before the general public was concerned about ethnic prejudice, psychologists were studying it as a social problem (e.g., Katz & Braly, 1933). Psychologists have often been first to advocate social policies such as affirmative action or the adoption of non-sexist language. Despite this longstanding commitment to tolerance, research has found that psychologists, too, sometimes evidence biases. In the past, most research of this nature has explored whether clinicians hold class, race, or sex biases. However, recently, evidence of another sort or bias, anti-religious bias, has been reported. A brief review of that literature finds:

1) Religion and religious people have been described in a predominantly negative fashion in the psychological literature (see Gartner, 1982 for a review), though recently the literature has reflected a shift away from this monolithically

negative stance (Bergin, 1983; Saffady, 1976).

2) Research on psychologists finds them to be unusually anti-religious. One study (Nix, 1978) found that 15% to 40% of the psychologists studied reported anti-religious attitudes, depending on how one defined the term. This is a dramatically higher figure than has been found among the general American population (Princeton Religious Research Center, 1982). While the general tendency for the educated to be less favorable towards formal/traditional religion (Argyle & Beit-Hallami, 1975) is undoubtedly a factor, it does not explain the entire discrepancy. Physical Scientists, who have an equal amount of education, have been found to evaluate religion more favorably than social scientists (Hoge & Keeter, 1976). Moreover, psychologists have been found to be the most anti-religious of the social scientists (McClintock, 1965).

3) A number of religious psychologists have claimed that the field is anti-religious, stigmatizing those who hold religious beliefs

(Bergin, 1980, 1983; Clement, 1978; Sollod, 1978; Van Leeuwen, 1983; Vitz, 1977).

4) Several authors have argued that many of the widely used personality tests are biased against religious people (Bergin, 1983; Gartner, 1981, 1983; Goldsmith & Harrig, 1978; Goldsmith & Sandborn, 1982; Vitz, 1982).

5) Content-Analysis of psychology texts reveal that religious experience and behavior is rarely discussed, despite the fact that over 3/4 of the world is religious in some fashion (Spika & Goldsmith, 1981; Vitz, 1982b).

Perhaps the most important question is how might psychologists' religious attitudes affect their professional conduct toward religious individuals? Nix (1978) found that, while 15-40% of her sample was anti-religious, only 1% said they would attempt to discourage a client's religious belief, which suggests that psychologists may well be able to respect their client's beliefs. On the other hand, Gartner (1982) found, in an analogue study on clinical psychology graduate admissions, that professors of clinical psychology were less likely to admit a Born Again Christian applicant and an identical non-religious applicant. This suggests that religious bias may affect some professional decisions.

A particularly important professional decision which

psychologists frequently make is a judgment concerning a client's degree of psychopathology. In the last 20 years this process has come under great scrutiny, both because of the great impact it can have on clients' lives, and because of the great potential for bias in what is in part a subjective judgment. The aim of this study is to assess the extent to which psychologists' clinical judgment may be influenced by a patient's ideological orientation. Relevant literature on bias in clinical judgment and values and psychotherapy are reviewed below.

Clinical Judgment Studies

The suspicion that prejudice might influence therapists' clinical judgments is not new. Attention to the problem was first aroused by Hollingshead and Redlich (1958) who found that lower class patients were more often assigned psychotic and other severe diagnoses than upper and middle class patients. This, plus the criticisms of labeling theorists and others such as Thomas Szaz (1974) about the diagnostic process, and the concern of the burgeoning community mental health movement for the delivery of quality mental health services to the poor served to make this a major issue in the field (Abramowitz & Dokecki, 1977). Research has focused on the influence of such factors as social class, race, sex and values on clinical decision making. The influence of religion, till now, has

been ignored, though the methods used in these previous studies could easily be adapted for research of this type.

Clinical judgment research can be almost exclusively divided into two groups: archival and analogue type studies (Abramowitz & Dokecki, 1977). Archival, or as they are sometimes called, epidemiological studies, involve examining the records of a mental health institution to see if differences can be found in the classification and treatment of socially marginal people. For example, it has been found that lower class patients are more often given severe diagnoses, less often accepted for psychotherapeutic treatment and usually seen for fewer sessions (Myers & Schaffer, 1954; Winder & Hersko, 1955). The problem with such research is that positive findings are consistent with, rather than univocally supportive of the bias explanation. These results may also reflect genuine differences between the classes in severity of pathology and resistance to psychological services. As the data is correlational, questions of causation remain moot. One solution to this dilemma is to include therapist characteristics as a variable in the study. For example, Yamamoto et al. (1967) found that therapists who were high in prejudice were less likely to have black patients in their long-term caseload. Results of this sort make one more confident in concluding that prejudice has, in some cases, exerted an influence on clinical judgment. Unfortunately few studies include such

factors.

The second major research strategy, the analogue study, borrows its methodology from experimental social psychology. Clinicians are given case material in which possible elicitors of bias (e.g., class, race, etc.) are systematically varied. For example, clinicians were found to evaluate patients more negatively on the basis of their Rorschach protocols when they were led to believe that the responses were produced by lower class patients (Levy & Kahn, 1970). With this type of research, we can be more certain that clinicians' evaluations are being influenced by knowledge of the hypothetical patient's group membership, as all other factors are held constant. In this way analogue studies are better controlled than archival studies. Inasmuch as they involve the systematic manipulation of variables they are experimental rather than correlational, and causal conclusions are more easily drawn. On the other hand, analogue studies do not measure "real life" behavior, as archival studies do. People do not always behave as their responses on a questionnaire might suggest (Ajzen & Fishbein, 1977). For this reason it is sometimes thought that converging evidence of bias from both archival and analogue studies is more convincing than either source alone (Abramowitz & Dokecki, 1977).

Analogue studies face another problem. Though positive results suggest that the clinician is responding to the

hypothetical patient's group membership, they do not assure us that prejudice is at work. In an analogue study the clinician is given relatively meager information compared to that he might normally have. Using his knowledge of the rate of mental illness in a particular population, he may allow that information to in fact guide his "best guess" about the case (Abramowitz & Dokecki, 1977). Put in statistical terms, he is in part, using the group mean to maximize his chances of being correct. As with the archival studies, one way to manage the problem is to study therapist factors. Abramowitz et al. (1973) found that conservative clinicians were more likely to stigmatize a political dissident. Results of this sort suggest that clinicians are not simply using well known statistical norms to guide their decisions, but are in fact affected by bias.

Listed in Charts 1 and 2 are some of the stimuli and dependent variables which have been used in past analogue studies. By far the most commonly used stimuli is a written case history on client description. Most dependent variables consist of bipolar rating scales of some kind, usually devised by the experimenter. Questions concerning diagnosis, prognosis, pathology and treatment recommendations are the most common dependent variables.

Below is a list of dependent variables used by Wallach and Strupp (1960) though some are redundant with variables already mentioned, the entire group are listed here, because

CHART 1
(based on review by Abramowitz & Dokecki, 1972)

Stimuli Used in Analogue Studies of Clinical Judgment

History/description
Test data (e.g., personality test score
Rorschach protocols)
Audiotaped interviews
Videotaped interviews
Live interview
Interview transcript
Adjective description
Family history/description
Group therapy incident
Gender

CHART 2
(based on review by Abramowitz & Dokecki, 1977,
except where indicated)

Dependent Variables Used in Analogue Studies
of Clinical Judgment

Diagnosis
Prognosis
Open-ended personality description
Personality rating scale
Semantic differential
Treatment recommendations
Family diagnostic evaluation
Open-ended therapeutic response to videotaped session
Educational and vocational oriented indicators
Adjective check list
Manifest need list
Frequency of encouraging statements made in role play
Frequency of "relationship building" statements
Severity of disturbance (Koppel & Farina, 1971)
Recommendation for discharge (Koppel & Farina, 1971)
Need for hospitalization (Blake, 1973)
Likability (Stein et al., 1972)
Discomfort with patient (Stein et al., 1972)
Interest in treating (Stein et al., 1972)
Potential for treatment (Blake, 1973)

their scale is the most comprehensive currently in the literature:

Diagnosis
Ego strength
Anxiety
Ego strength
Insight
Emotional maturity
Social adjustment
Degree of disturbance
Similarity to patients now have in therapy
Kind of treatment recommended
Motivation
Chance of acting out
Recommended frequency of sessions
Would you make extensive changes in character structure
Recommended length of treatment
Permissiveness
Encourage free association
Change usual therapeutic approach
Recommendations to patient
Prognosis with therapy
Prognosis without therapy
Willingness to accept patient into treatment
Ease of empathy with patient
Environmental stress
Therapists' attitude

There is not room here to fully review the results found in this literature (see Abramowitz & Dokecki, 1977; Gurman & Razin, 1977). A brief overview is enlightening. The first patient attribute intensively studied with these techniques was social class. More than any other factor studied since, social class was found to have a consistent effect on clinical judgment: "...research suggests that lower class individuals are clinically devalued more consistently than are minority persons, women or social nonconformists" (Abramowitz & Dokecki, 1977, p. 464). These findings are consistent with literature on what has been called the YAVIS (Young, Attractive, Verbal,

Intelligent, Successful) Client. Research (Garfield & Bergin, 1978) shows that this type of patient, who is of course disproportionately represented among the upper classes, is preferred by most therapists and tends to benefit most from psychological services.

The prediction that clinicians would evaluate racial minorities more negatively than caucasions has not been substantiated (Abramowitz & Dokecki, 1977; Sattler, 1977). Both archival and analogue studies have failed to show a consistent anti-black bias. The majority of studies produced null results. Some have found pro-black responses among white and black clinicians. Anti-black findings are the most rare. One of the few studies to find that blacks were given a more severe diagnosis admittedly used a highly ambiguous case (Blake, 1973). Even in this study subjects did not differentiate the black and white patient on such variables as adequacy of ego function, interest in treating or prognosis.

While clear-cut bias has not been found, there is evidence that clinicians attend to race when making clinical judgments. Goldstone (1971), for example, found that blacks were rated better than whites if both were described as "good therapy risks" but worse if both were described as "poor risks." The investigator concludes that minority status is seen as a handicap; therefore, if a black is a good risk he must be exceptionally able in order to overcome his handicap. If

he is a "poor risk" then he most likely is in worse shape than a comparable white patient who does not have an extra impediment.

It is also possible that the clinicians participating in such studies are "wise" to the analogue method and thus, bend over backwards to avoid appearing prejudiced. As Abramowitz and Dokecki (1977) note, the studies in this area are virtually devoid of manifestation checks.

Though clinicians have been found to hold sex role stereotypes (Rabkin, 1977), there has been little support for the notion that they are biased against women (Abramowitz & Dokecki, 1977). As with minorities, however, clinicians have been found to respond differently to female clients. Male clinicians actually tend to prefer their female patients and see them for more sessions. However, that extra degree of interest sometimes has sexualized or voyeuristic overtones (Abramowitz & Dokecki, 1977). For example, psychiatric residents show more TAT cards concerning romantic themes to women (Masley & Harris, 1969; Siskind, 1973). One study worth noting did find bias against women using neither the archival or analogue method. Broverman et al. (1970) found that clinicians' ratings of the ideal man were closer to their ratings of the ideal person than were their ratings of the ideal woman.

Next to patient social class, patient's values have most consistently been found to affect clinicians' judgmentation

(Abramowitz & Dokecki, 1977). However, even results in this area have been mixed. Of the ten studies reviewed by Abramowitz and Dokecki (1977), three found positive results, three null findings, and four mixed results. They report two studies (Abramowitz et al., 1973; Braginski & Braginski, 1974) which reported bias against the political dissident, especially among Conservative clinicians. More mixed results on patient sex type, which could be considered a value dimension, have been found. Two studies (Schlosberg & Pietrofesa, 1973; Thomas & Steward, 1971) found that women contemplating masculine occupations were judged more pathological. However, another set of investigators (Abramowitz et al., 1976) failed to replicate these findings. Yet another study found feminine typed women elicited more empathy and liking than masculine typed, but that the masculine typed were judged more mature (Gomes & Abramowitz, 1976).

At least three studies on the influence of a client's religious values on clinical judgment have been reported. Using a sample of only three clinicians, Gerrard (1968) found that they were more likely to predict that abnormal MMPI scores came from a Christian snake-handling sect than a conventional church, despite the fact that research has shown no difference between these groups on the MMPI (Tellegen et al., 1969). Clearly, more research is needed in the area of religious values and clinical judgment. However, Hong (1978) found

that seminary students did not differ in their clinical ratings in response to manipulations of the client's religious orientation or type of conversion. Lewis (1983) found that clinicians listening to a taped interview with a depressed woman did not differ in their ratings when the patient used religious language and was identified as an evangelical Christian.

Perhaps the final question one might ask of this literature is "Why does it matter if prejudice influences clinical judgment?" There are several answers to this question. First, as the labeling theorists of the 1960's were the first to point out, diagnostic labels can have a stigmatizing effect on the individual. If clinicians are prone to assign more severe labels to certain groups, that action has tangible political, economic, social and psychological negative consequences for the individuals in those groups. Secondly, members of groups not favored by psychologists may find the path to psychological services they need partially blocked. The reader will recall that lower class patients, for example, are less often accepted as patients, usually assigned to less skilled personnel and seen for fewer sessions than middle or upper class patients (Myers & Shaeffer, 1954; Winder & Hersko, 1955). More tangible, but no less important, how will the therapist's attitude toward the patient affect his ability to provide his normal level of quality services? Concerning this question, Hans Strupp wrote:

> ...in all the investigations the therapist's attitude toward the patient as rated by himself showed a highly significant statistical relationship to his clinical judgments and treatment plans, and where such data was obtained, to the emotional tones of his communications. In recent studies, an item which inquired whether the therapist felt warmly toward the patient proved particularly predictive. For example, negative attitudes toward the patient were found to be correlated with a more unfavorable diagnosis and prognosis, with recommendations for greater strictness and activity on the part of the therapist; with recommendations for less frequent interviews; with greater unwillingness to treat him...
>
> It is yet unknown to what extent the patient may fulfill the therapist's unverbalized prophecy. This much, however, is clear. In the absence of a keen and abiding interest and dedication to the part of the therapist, the patient cannot marshal the necessary strength and energy to fight his way to a healthier adaptation, or, to use Dr. Alexander's felicitous term, he cannot undergo a corrective emotional experience. (Strupp, 1963, p. 78)

Further, therapists' negative attitudes towards marginal groups may create/interact with the defensiveness that some members of those groups might feel when entering therapy. Relating this point to our topic, King (1978) found that only a minute percentage of the Evangelical Christians in his sample said they would consider seeking psychological services even if they had a psychological problem. The most common reason subjects gave was their fear that the therapist would misunderstand or challenge their faith. When one considers that Evangelical Christians compose 17% of this nation's population (Princeton

Religious Research Center, 1982), the scope of the problem becomes apparent. Put in this context, it appears to be of more than academic interest to discover if psychologists are biased in their clinical judgments of the religious.

Values and Therapy

Between the late fifties and early seventies, psychologists showed a great deal of interest in the relationship of values to therapy. Reviews of the literature (Beutler, 1972; Ehrlich & Weiner, 1961; Kessell & McBrearty, 1967; Patterson, 1959) appear to converge on four basic findings, each of which has implications for our topic.

1. In many cases therapists appear to communicate their values to their patients

It has long been a truism that therapists should not "impose their values" on their clients. Initially, this position grew out of psychoanalytic theory which argued that any attempts at moral persuasion would interfere with the interpretive process. This stance of value neutrality was later buttressed by the emergence of the client centered approach which emphasized the therapist's non-directive role in helping the client to choose his own values.

In the late fifties and early sixties, however, psychologists and other clinicians began to question whether the noble goal

of value neutrality was really possible in the context of the therapeutic relationship. Beutler (1972) and Kessell and McBrearty (1967) cite almost a hundred authors writing during this period who came to the conclusion that it was not possible. Indeed, as early as 1953, the American Psychological Association explicitly state in their code of ethics that the values of the psychotherapist are expressed in the clinical relationship. Wolf (1956) found that 40% of his New York therapist sample believed that the values of the therapist have direct influence on the client. Only 25% denied it. In a more recent survey (Roche Labs, 1974), 65% of the psychiatrists polled agreed that "Psychiatrists attempt to influence patients to 'adjust' to the psychiatrists' own [sex role] stereotypes."

The conclusion that the values of the mental health professional are inevitably expressed to the patient rests on two arguments. First, as London (1964), among others, has suggested, the goals of psychotherapy itself rests on implicit value assumptions. Some clinicians have obscured this point in the past by describing abnormality and treatment in the language of the medical model. Such an analogy implies that mental health, like physical health, can be defined in objective terms, when in fact psychological theories of "the Good," to borrow Plato's term, are usually based on untested and often untestable value assumptions. One theory's concept

of health may not agree with others.

The second argument is that therapists communicate their values indirectly, sometimes unconsciously, even if they refrain from directly imposing them. It is widely acknowledged by psychologists that people communicate a great deal about themselves in a variety of verbal and nonverbal ways that they may not recognize or be able to control. We can only conclude that this must also be true of psychologists themselves and their values. Meehl (1959) provides an example:

> I think it is naive to assume that because a therapist does not explicitly assert to his patient that he, the therapist, has certain views about religion, or values or philosophy of life, therefore he is not presenting to the patient any value model. Surely one does not have to engage in conversation regarding his own moral philosophy in order to get across the message.
>
> Consider, for example, the problem of guilt for one's thoughts. There are important (and psychologically significant) differences here between Roman Catholics, Lutherans and Humanists. To a Lutheran, objective guilt does attach to evil thoughts. To a Roman Catholic, objective guilt attaches to evil thoughts only under certain conditions (e.g., when the individual freely dwells on them instead of struggling against them). To most Humanists thoughts which do not result in overt actions are free of guilt. I have listened to enough tape recordings to believe that in reflection, interpretation or leading questions regarding a patient's thoughts, therapists often tip their hand, by inflection or choice of words as to where they stand in this regard: A message which says "Come now, you and I are both rational, mature, emancipated individuals, and therefore

> we know that a person ought not feel guilty about his fantasies. (Meehl, 1959, pg. 256)

The hypothesis which follows from this discussion is that some therapists may communicate values antithetical to those of their clients, especially when their client subscribes to an extreme ideological belief system. Though there are numerous anecdotes which have been told to the author which are consistent with this hypothesis, it has never been tested empirically. Nix's (1978) finding that only one percent of her sample claimed that they discourage the religious beliefs of their clients, suggest that the attempted value influence may not be of a conscious overt nature. Almost half of her sample said they would "explore" the client's religious beliefs. As in the above example provided by Meehl, the therapist's own views may seep through in this "exploration process."

2. Patients tend to adopt their therapists' values

If therapists do indeed communicate their values, one would expect that many patients might be receptive to adopting those values. Petoney (1966) found that outpatients at a client centered counseling center at the University of Chicago moved closer to their therapists' values during the course of therapy. Petoney suggested that his results could be explained in two ways. Either the therapist communicates his values to the client, or the client as a result of therapy, acquires a more mature healthy approach to living and hence approximates

more closely the orientation of his therapist.

Welkowitz, Cohen and Ortmeyer (1967) found results more consistent with the former explanation. They found that patients were closer in values to their own therapists than were randomly assigned therapist patient dyads, suggesting that patients are indeed adopting the values of their particular therapist, rather than general "healthy" therapist values. (Initial patient selection did not seem to be a factor, as therapists were assigned cases by an intake worker on the basis of availability.) Others (Burdock et al., 1960; Morris et al., 1960) have found that patients and therapists cannot be distinguished on the basis of their values, further casting doubt on the "healthy therapist values" hypothesis.

The competing notion that therapists may in fact be influencing their patients' values is certainly consistent with what social psychologists have discovered about the process social influence. Patients are troubled people seeking help from an authoritative expert with whom they will become quite intimate; this should make them receptive to influence on a number of counts. Indeed, some authors have tried to explain the entire process of psychotherapy in terms of the social influence literature (Beutler, 1971; Strong, 1978). Behavioral principles might also be invoked to explain this phenomenon. Truax (1966) analyzed transcripts from client centered therapy and noticed that the therapists selectively reinforced with

a supportive remark or gesture statements which were consistent with the humanistic world-view after which the frequency of such verbal behavior increased.

Undoubtedly, more research is needed on how, why and when client's values change to draw any firm conclusions. It would be interesting to see if religious clients become less religious after therapy than a matched waiting list control, or to broaden the question, in what, if any, way they would change.

3. Patients tend to be rated as more improved if they adopt their therapist's values

The first study of this type was done by Rosenthal (1955) who found that improved patients tended to revise their values in the direction of the therapist. Though he did not obtain significant results on the Allport-Vernon-Lindzey scale of values, he did on a moral values scale which measured moral beliefs concerning sex, aggression and authority. This suggests that some value content may be more closely associated with rated improvement than others. Obviously moral beliefs concerning sex, aggression and authority are closely connected to religious values (an examination of the actual items on the scale confirms this, e.g., "Girls should come to the marriage bed as virgins," is a belief of traditional Judaism and Christianity). The fact that these were the values found to be relevant to therapeutic outcome suggests that there is need for more empirical study

of psychotherapy and religious values. Unfortunately, Rosenthal does not report if improved patients become more liberal or conservative in their views, only that they come closer to the views of their therapist (not reported).

Tentative support for Rosenthal's findings was found by Parloff, Iflund and Goldstein (1957). They asked two psychiatric inpatients to rank the importance of various issued discussed in therapy. The patient who was rated as most improved and subsequently discharged became relatively closer in his rankings to those supplied by the therapist. Schrier (1953), though not directly concerned with values, found that reported improvement was related to the extent that the patient developed identification with the therapist's need system. In what is probably the most methodologically sound study in this area, Welkowitz, Cohen and Ortmeyer (1967) found that therapists' ratings of patient improvement was correlated with therapist patient similarity on the Strong Vocational Interest Blank and the Morris Way to Live Scale. Finally, in a somewhat related study, Burdock et al. (1960) found that therapists who adopted the interest patterns of their supervisors were rated by their supervisors as better adjusted.

Partially contradictory findings were found in three studies (Farson, 1961; Holzman, 1961; Nawas & Landfield, 1963). Farson (1961) found adoption of the therapist's values to be related to outcome only among less adjusted and less competent

clinicians. Kessel and McBrearty (1967) suggest that the difference in Farson's and Rosenthal's findings may be due to the fact that Rosenthal's sample was composed of psychoanalytically oriented psychiatric residents while Farson studied client centered therapists. These two orientations have different value systems themselves, with client centered therapists sometimes being more adamant about not influencing client values. One could also speculate that psychiatric residents may not be the most competent clinicians. Holzman (1961) found that successful outpatients tended to adopt their therapist's values, but that the opposite was true of inpatients. Finally, Nawas and Landfield (1963) reported nonsignificant results which seemed contrary to those of Rosenthal. However, when they added more subjects to their sample (Landfield & Nawas, 1964) they indeed did find that improved patients tended to shift their real self-ratings closer to the therapist's ideal self-ratings, provided it was described in the patient's language.

As with many of the other findings we have reviewed, these are almost entirely correlational, and more than one plausible explanation presents itself. Taking these results at face value, the acceptance of a therapist's values may in some way be related to improvement in therapy. This may be because the therapist's values are "healthier." An alternate explanation is that increasing value congruence may be one

cause/result of increased intimacy and receptivity to therapeutic influence. If one wanted to be a bit more skeptical, one could suggest that clients who adopt their therapists' values may be rated as more improved without actually being so, because they now appear more attractive to the therapist whose values they have accepted. The fact that some studies such as Rosenthal (1955) and Holzman (1961) have used outcome criteria more objective than therapists' ratings, such as independent interviews, personality tests or objective data, makes this explanation less likely. However, as some (Bergin, 1983; Gartner, 1981, 1983b; Goldsmith & Harrig, 1978; Goldsmith & Sandborn, 1982; Vitz, 1982) have suggested, personality tests and "independent" interviewers can share many of the therapists' value biases. Thus, further analogue research on therapist-patient value congruence and clinical judgment is needed to supplement these correlational findings.

4. Patients tend to improve more with therapists who initially share their values to a moderate degree and do worse with therapists who are highly dissimilar

The research reviewed above examined the relationship between value change during therapy and therapy outcome. Research has also been done on the effect of initial therapist-patient value similarity on outcome. Cook (1966) had prospective clients at a college counseling center and their clinical staff fill out the Allport-Vernon-Lindzey scale

of values. He then assigned clients to either a high, medium or low similarity therapist. He discovered a curvilinear relationship between similarity and outcome. His results showed that clients working with a medium similarity therapist did the best, followed by the high similarity group, with the low similarity group doing the worst. This finding is paralleled by others (Berzin, 1977) which have found a curvilinear relationship between patient-therapist personality similarity and therapy outcome. Perhaps too high a degree of similarity makes it hard for the therapist to be objective, as his own conflicts and biases may be confounded with those of the patient. On the other hand, too little similarity may make it difficult for the therapist to empathize with the client or for the client to trust the therapist. A substantial number of authors agree that a high degree of value dissimilarity is an impediment to therapy (Beutler, 1972). On this basis, one might predict that highly religious patients might not improve as much in psychotherapy as less religious patients. Rosenbaum et al. (1956) discovered just that.

In a more recent study (Pettit, Pettit & Welkowitz, 1974) no relationship was found between value similarity and duration of therapy though they used a large sample (104 therapists, 249 patients). The investigators used factor analysis to consolidate six major interest factors from several measures (Rotary Club vs. aesthetic interest, authoritarian submission

vs. independent, transcendentalism vs. concrete rational).

Is Religion Hazardous to Your Mental Health?

One of the most important criticisms of analogue research on clinical judgment has been that clinicians' ratings may be influenced by their knowledge about the rate of mental illness in different populations, rather than prejudice. Thus, in proposing an analogue study on religion and clinical judgment, it is important to ask in advance, "Is there a greater rate of mental illness among the religious?" For if there is, our results may not be as easily interpretable.

A number of review articles on this topic can be found in the psychological literature (Argyle & Beit-Hallahmi, 1975; Becker, 1971; Bergin, 1983; Dittes, 1971; Gartner, 1983b; Sanua, 1969; Spilka & Werme, 1971; Stark, 1971). The overwhelming finding, perhaps to the chagrin of both the pro- and anti-religious, is that the religious appear to be no more or less healthy than the nonreligious. As Sanua (1969) concludes: "The results of the above review seem to indicate therefore, that most studies show no relationship between religion and mental health..." (pg. 100). In a more recent review Bergin (1983) summarizes his findings as follows:

> The data provide surprising results. Of the 30 effects tabulated, only 7 or 23% manifested the negative relationship between religion and mental health assumed

> by Ellis and others. Forty-seven percent indicated a positive relationship, and 30% a zero relationship. Thus 77% of the obtained results are contrary to the negative effect of religion theory. Although most of the results were not statistically significant, the overall pattern was interesting. Considering statistical significance of results, 23 outcomes showed no significant relationship, 5 showed a positive relationship and 2 showed a negative relationship. (Bergin, 1983, pg. 176)

In reviewing the literature on religion and self-esteem, an important aspect of mental health, Gartner (1983b) found a remarkably similar distribution of results. Of the 18 studies reviewed, 4 found the religious lower in self-esteem, 8 found no difference, and 6 found the religious higher in self-esteem. As in Bergin's review, exactly 77% of the findings are inconsistent with the proposed negative relationship between religion and mental health.

As our study concerns the traditionally religious in particular, literature on this degree of adjustment is particularly relevant. In his review, Becker (1971) found three studies which compared theological liberals to theological conservatives. Between the three studies a total of 18 personality tests were administered to samples from these two populations, almost wholly without results. Becker concludes:

> The attempts of Rank, Lee and Dreger to establish personality substrata for theological liberals and theological conservatives should tell us that this is an unproductive line of pursuit....While liberalism and conservatism may be the source of much

> friction in theological circles, the content of one's theology is apparently not the dimension on which to establish the possible correlates of psychological health. (Becker, 1971, pg. 399)

Clearly, more research is needed in this area, however.

Finally, one must ask if research has shown differences with respect to adjustment between subjects who are more extremely conservative in their theology, such as Evangelicals and Fundamentalists, and those who are liberal or nonreligious. Unfortunately, there is no review article on this topic to the author's knowledge. Goldsmith (1983) recently reviewed the last decade of research which appeared in The Journal of Psychology and Theology, an Evangelically oriented psychological journal. He reports that "none of the studies reviewed reported clear differences between (Evangelical) Christians and others on general measures of personality or adjustment measures" (pg. 15). This author was able to find four relevant studies in the psychological literature concerning the mental health of Fundamentalists. Stanley (1963a, 1963b) was unable to find any difference between fundamentalist Christians and non-fundamentalist Christians on the MPI measure of neuroticism or the Cattel and Schrier (1961) Neuroticism scale questionnaire. In a later study Stanley et al. (1975) compared fundamentalists to secular college students on the Eysenck Personality Inventory and found the religious students to be less neurotic. Hassan (1978) found the same results using the scale. Thus, the

overall finding, once again, appears to be that no consistent direction of differences can be found.

Going beyond the simple question of whether the religious are more or less well adjusted than the nonreligious, there may be differences in their respective types of adjustment. There may be assets and liabilities inherent in both life styles.

Beginning with religion's liabilities, it has repeatedly been found that the religious are more "authoritarian" than the nonreligious (Adorno et al., 1950; Dittes, 1971; Sanua, 1969; Simpson & Yinger, 1972; Spilka & Werme, 1971). However, some authors (Hogan & Emler, 1978; Gartner, 1983b) have argued that the F scale, the instrument used to measure authoritarianism, is biased against subjects holding conservative and/or religious values. Thus, it is difficult to determine whether or not these results are simply an artifact of the instrument used. This appears to be a common problem when considering research on religion and mental health. The traditionally religious and psychologists, who are for the most part secular humanists, have vastly different definitions of what constitutes mental health. However, because psychologists incorporate their notions into personality tests, they appear somehow objective and scientific. If religious populations score poorly on these tests, it is taken as evidence that they are impaired, when they may simply hold different values. As Bergin (1983)

has stated:

> ...mental health criteria ultimately consist of standards based on subjective values. Thus, many of the "proofs" that religion is a source of disturbance are merely tautologies that only prove that two sets of personality measures constructed by people holding the same premises are likely to correlate. This circularity is obscured by an empirical posture. (Bergin, 1983, pg. 172)

(For an example of such circularity see Gartner (1981) who found that widely reported results showing the religious to be less self-actualized than non-believers was a clear artifact of the instrument, the Personal Orientation Inventory, which was used in these studies.)

These objections noted, there is evidence from other sources which is consistent with Adorno et al.'s (1950) original contention that the religious are more strongly defended, closed minded and constricted in their personalities (Spilka & Werme, 1971; Dittes, 1971). For example, several studies have found the religious to score higher on the MMPI L and K scales (Argyle & Beit-Hallahmi, 1975; Dittes, 1971; Martin & Nichols, 1962), considered to be measures of defensiveness. More research, and more careful scrutiny of existing research is needed in this area.

A large body of research has linked religion to prejudice (Argyle & Beit-Hallahmi, 1975; Dittes, 1971; Simpson & Yinger, 1971). (Whether prejudice can be considered a sign of poor adjustment is perhaps debatable. This author will show his

liberal bias and assume that it is.) However, a more recent review by Gorsuch and Aleshire (1974) has revealed that the relationship is not so simple. In studies where subjects have been divided into intrinsically and extrinsically religious, the intrinsics have consistently been found to be less prejudiced than average, while the extrinsics are consistently more prejudiced. This suggests that those who are personally committed to their faith have genuinely internalized its humanitarian ideals, while those who go to church for material advantages or simply as part of an identification with "the American way of life" are likely to adopt the American way of prejudice as well. Consistent with these findings, several studies found a curvilinear relationship between prejudice and church attendance. Those who were least prejudiced either never attended church or went more than once a week. The "Sunday morning" Christians were found to be the most prejudiced. This pattern of findings was not replicated for fundamentalists, who were found to be more prejudiced than others, regardless of intrinsic-extrinsic orientation and degree of participation. Unfortunately, Gorsuch and Aleshire (1974) do not report if any of these studies controlled for education which correlates negatively with both prejudice and fundamentalism (Argyle & Beit-Hallahmi, 1975; Simpson & Yinger, 1971).

In contrast, research has shown religion to be a psychological asset in a number of different respects. However, there are

questions concerning the interpretation of these results as well. One problem is that simplistic measures of religiosity are often employed. Sociologists of religion have devoted a great deal of attention to the simple question of how does one measure religion? (Yinger, 1970). Glock and Stark (1965), for example, have divided religiosity into five dimensions: belief, practice, experience, knowledge, and consequences. Sometimes research employing different dimensions as their measure of religiosity will obtain different results. For example, church attendance (participation dimension) has been found to correlate negatively with mental illness, physical illness, suicide, criminal behavior and alcoholism (Argyle & Beit-Hallahmi, 1975). However, juvenile delinquents, alcoholics and patients who have attempted suicide do not differ from others in their religious beliefs (Argyle & Beit-Hallahmi, 1975). It may be that religious faith is not enough to gain the mental health benefits of religion. Participation in the religious community, which provides support and structure for the individual, may also be an essential element. On the other hand, one could argue that as people deteriorate psychologically they drop out of organized social activities like church. As the data is correlational, questions of causation cannot be determined.

A second line of research shows that the religious are more likely to report being personally happy (Ellison & Paloutzian,

1979), and satisfied with their marriages (Argyle & Beit-Hallahmi, 1975; Chesser, 1956; Dyer, 1961; Landis & Landis, 1953). The latter finding, in particular, has been replicated numerous times. "In all the studies in which religious variables have been included, the more religious people have claimed to be more happily married. The differences are not large, but they are consistent" (Argyle & Beit-Hallahmi, 1975, pg. Such results are consistent with religion's claim to meet man's highest needs and its emphasis on positive family life. However, these results, too, must be interpreted with caution. In light of the finding that the religious tend to "fake good" or be more defensive on MMPI L and K scales, they might be likely to paint an unrealistically rosy picture on self-report scales concerning personal and marital happiness also. One is often encouraged to think and talk positive in religious circles. In addition, cognitive dissonance might cause many religious to overestimate their marital happiness as religious doctrine sometimes makes divorce difficult or impossible. (A religionist could respond to this argument by saying that "learning" to be happy with one's spouse may often be preferable to breaking up families. Thus, the questions may be irresolvable on the empirical level.)

It is clear that the conclusions one can draw from this data are far from definitive. The pro-religious reader could conclude that, excepting the results obtained with a series

of biased personality tests, the religious came out ahead on all the objective "real-world" criteria (e.g., physical illness, suicide, etc.). The anti-religious reader, on the other hand, could concede that the religious gain some minor benefits from leading "straight" and "wholesome" lives, but argue that they pay for those benefits through severe self-imposed limitations on their emotional and psychological functioning. The truth may indeed be somewhere in-between. The structure provided by religion may be a double edged sword which provides support, endurance and security, but also limitations and sometimes rigidity. The humanist may be more creative, but he is also more likely to divorce, go insane, or commit suicide. Who is to say which is better? This is a question to be answered on the bases of values, not scientific inquiry.

One final way in which one may examine the data is to admit that the question, "Is religion (traditional or not) good for your mental health?" is the wrong question. We might do better to try to differentiate ways of being religious (traditionally or nontraditionally) which are healthy from those which are not. For example, the Gorsuch and Aleshire (1974) article cited earlier showed that intrinsic and extrinsic religiosity have opposite relationships to prejudice. Though Gartner (1983) in his review found no relationship between self-esteem and religiosity, he did find a consistent positive relationship between loving God images, as contrasted to judgmental

ones, and self-esteem. Psychologists may indeed be right that the quality of one's mental health is related to one's religious beliefs. Perhaps the field has spent too much time trying to damn or vindicate religion as a whole to fully explore what these relationships might be.

In summary, research has failed to find any consistent relationship between religion and mental health. Thus, in undertaking an analogue study on religion and clinical judgment, one does not need to be concerned that clinicians will utilize empirically valid norms as a factor in their decisions, for clear norms relevant to this question have yet to be found.

CHAPTER II

OVERALL DESIGN AND HYPOTHESES

Overall Design

Doctoral level clinicians were asked to read two patient case histories. (These two cases were pre-judged by raters to be similar.) In one of these cases, the patient was described as holding an extreme ideological orientation, while in the other they were not. Four orientations were systematically varied between the two cases: conservative religious, conservative political, liberal religious, liberal political. In a sense, the other three ideological groups serve as controls for the extreme conservative religious patient. They allow us to examine separately the impact of a patient's holding to a belief system which is a) extreme, b) conservative or liberal, or c) religious or political. Subjects also filled out a brief questionnaire about their own demographic background and ideological position.

Hypotheses

This study raises three basic questions, each with a corresponding hypothesis or set of hypotheses.

Question 1

Are patients viewed more negatively if they hold an extreme ideological orientation?

Hypothesis 1A. Patients holding an extreme ideological position will be rated more negatively than patients who do not hold such an orientation.

Hypothesis 1B. Ideological patients will be assigned more severe diagnoses. Specifically, they will more often be assigned a) DSM-III axis II diagnoses (American Psychiatric Association, 1980), and b) the diagnoses of obsessive compulsive or compulsive personality disorder (recall Freud believed religion to be an obsessive compulsive neurosis).

Question 2

Will clinicians differentiate between the four groups in their ratings? Three degrees of freedom allow for three planned contrasts.

Hypothesis 2A. "Liberal vs. conservative" patients. Given that most psychologists are liberals, the conservative groups will be rated more negatively than the liberal groups.

Hypothesis 2B. "Religious vs. political" patients. Given the long anti-religious tradition in psychology, religious patients will be viewed more negatively than political ones.

Hypothesis 2C. "Conservative religious vs. the other" patients. For both of the above reasons, the conservative

religious group will be rated the most negatively of all.

Question 3

Will the demographic and ideological traits of the rater interact with the ideology of the patient in its effect on the rater's responses?

Hypothesis 3A. Politically liberal clinicians will rate conservative patients more negatively than they will rate liberal patients. Conservative clinicians will react in the opposite way.

Hypothesis 3B. Religiously liberal clinicians will rate conservative patients more negatively than liberal patients. Traditionally religious clinicians will react in the opposite way.

Hypothesis 3C. Clinicians who themselves indicate an extreme position on the political or religious ideology scales will evidence the above effects more strongly than will moderates.

Hypothesis 3D. Northeasterners, and possibly Californians, who as groups tend to be more liberal, will react more negatively to the conservative patients than will the rest of the country.

Hypothesis 3E. Consistent with past findings (Gartner, 1982), Jews will react more negatively to the conservative religious patient (a fundamentalist Christian) and possibly to conservative groups in general, than Gentiles.

Hypothesis 3F. Inasmuch as psychoanalytically oriented

clinicians are more prone to infer pathology from behavior which may not be overtly symptomatic than are behaviorists, psychoanalytic clinicians will react more negatively to the ideological patients.

Hypothesis 3G. Inasmuch as women are more religious than men as a group, women will react less negatively to the conservative religious patient than men.

Hypothesis 3H. Given the negative attitude most conservative groups have long held towards homosexuality, homosexual clinicians will react more negatively to conservative patients and more positively toward the liberals than heterosexuals.

In addition to the above hypotheses, the influence of therapist race, age and social class of origin will be explored.

CHAPTER III

METHOD

Sample

The primary sample for this study was a group of clinical psychologists whose names were obtained from the National Register of Mental Health Service Providers. Eighteen hundred randomly chosen names were sent the study by mail. In an effort to recruit a traditionally religious subsample an additional 340 questionnaires were sent to a group of clinicians listed in the Directory of the Christian Association for Psychological Studies. CAPS is a professional organization for Evangelical Christian psychologists. (Ideally, to insure that this group was comparable, only those names which appeared in both the CAPS Directory and the National Register would have been included in this subsample. However, due to the small number of CAPS members, all doctoral level clinicians whose credentials were those of the traditional mental health professional (e.g., Ph.D., Ed.D., M.D.) were included.

Materials

The Case Reports

Two case histories were needed for this study. Care

was taken in choosing these cases to insure a) that no bias on the part of the experimenter influenced their selection, and b) that they were reasonably comparable in the ratings they would receive on the dependent variable. A three-step procedure was followed in an effort to achieve this aim.

All potential cases were chosen from the records of the Psychological Services Center of the University of Massachusetts. All initial psychotherapy summaries which concerned adults, followed the standard format and did not exceed two single spaced pages in length were included for consideration after identifying data was removed or changed.

This unwieldy pool of 117 cases was reduced to a more manageable group of finalists by having 12 graduate students in clinical psychology each rate 10 cases on the clinical judgment scale (CJS) used in the study, as well as indicate how well written each case was on a 7-point scale. All cases which were within 2/3 of a standard deviation of the mean and rated as well written were included in the final pool.

At the third and final stage three advanced doctoral students in clinical psychology rated the remaining 21 cases on the CJS. They achieved an overall reliability score of .72 on three test cases before rating the final 21, and .65 on the final 21. While this is not exceedingly high, it should be noted that it was decided that the raters would not be trained before making their ratings, which most likely contributed

toward keeping the reliability score low. The reason for this was that it was believed that three clinicians each reflecting their own notion of health and sickness would better represent the diverse population of psychologists than raters trained to respond in accordance with a particular model.

The two final cases to be used in the study were to be those two a) whose mean ratings on the CJS were closest, and b) who were reliably rated at the .8 level or better by the three raters.

The two cases chosen (see Appendix A) were Mr. S, a 28-year-old black male graduate student from the Virgin Islands who reports a history of stammering, social anxiety and perfectionistic tendencies, and Mr. W, a 27-year-old white male college student who presents a history of unstable relationships, depression and familial conflict.

The Experimental Manipulation

The ideological groups used. It was necessary to pick four specific groups to represent the conservative religious, conservative political, liberal religious and liberal political conditions specified in the design. Unfortunately, we were able to think of no objective way to find four "equally extreme" groups, since the designation of extremism usually reflects the ideological position of the rater to some degree. Therefore, the task was left to the judgment of the experimenter. The

following choices were made:

Conservative Religious (CR): "Born Again" Fundamentalist Christian;

Conservative Political (CP): John Birch Society;

Liberal Religious (LR): Atheist International;

Liberal Political (LP): American Socialist Party.

The insertion of ideology into the case history. The reader will recall that each subject rated one non-ideological patient and one ideological patient. Mention of the patient's ideology was inserted at four points in the case history. In the first section, "identification of the patient," two sentences were added at the end: "Further, the client makes note of the fact that he is 'extremely conservative religiously (CR), conservative politically (CP), anti-religious (LR), radical politically (LP).' Currently he is a member of (organization name)." In the "presenting problems" section the sentence was added, "At times Mr. S/W describes these problems in the language of his ideological system, which he says plays a central role in how he conceptualizes himself and his world." In the middle of the report in the last sentence of "current life situation" the sentence "Mr. S/W also spends a lot of his time in religious/political activities" was added. To control for the perceived effect of mere involvement in group activities the sentence, "Mr. S/W also participates regularly in the events of several local community organizations"

was placed in the corresponding section of the non-ideological patients' histories. Finally, at the end of the report in the "diagnostic hypotheses" section, the sentence was added "Further assessment should reveal what role, if any, Mr. S/W's ideological beliefs play in his pathology or adjustment."

The Dependent Variables

The clinical judgment scale used in this study (see Appendix B) was a modified form of that introduced by Wallach and Strupp (1966). Though not used extensively, this scale had a more comprehensive set of questions (21 items) than most. Unfortunately, the tradition in this area of research has been to write a new, usually very brief, scale for each study. No standard well validated instrument has emerged. Four dated questions were dropped from the CJS and the response scales were changed from 5 to 7 points, leaving 16 closed ended items and one open ended (diagnosis). Again, it was predicted in hypotheses 1 and 2 that ideological patients, particularly those who were conservative, religious, or both, would be rated more negatively on this scale than non-ideological patients.

Demographic and Ideology Questionnaire

Subjects filled out a second questionnaire (see Appendix C) designed by the experimenter in which they indicated basic demographic facts about themselves (e.g., sex, age, race,

religion, family of origin religion, geographic region now residing, geographic region of origin, social class of origin, sexual orientation) as well as their ideological position with respect to psychology, politics and religion. To reduce the possibility that examining this questionnaire might alert subjects to the purpose of the study and thereby influence their responses on the CJS, the demographic questionnaire was stapled shut and stamped with the message "Please do not open until case ratings are completed." Of course, our third set of hypotheses relate to the influence of these factors on subjects' CJS ratings.

Procedure

Instructions to Subjects

In the attached cover letter subjects were told how we got their names, and asked for their participation in the "psychotherapy research project at the University of Massachusetts." They were told that the purpose of the study was to understand how "therapists respond to and evaluate clinical material." They were asked to rate both cases on the CJS and then fill out the demographic questionnaire. At the bottom, a brief handwritten note thanked them for their participation.

Subjects were also told that they, of course, did not

have to participate, their responses would be confidential, and that they indicated their willingness to participate by mailing back the questionnaire. A brief summary of the results could be obtained by mailing a stamped self-addressed envelope.

What Was Done

Two thousand one hundred forty sets of cover letters, cases, questionnaires and business reply envelopes were mailed to prospective subjects. An equal number of each case X ideology combinations (10 in all) were randomly distributed to the prospective subjects.

CHAPTER IV

RESULTS

The Sample

Three hundred sixty-three (18%) of the potential respondents returned usable data. A summary of the distribution of demographic and ideological characteristics of the sample can be found in Table 1.

Not surprisingly, the sample is composed predominantly of white male heterosexuals (see Table 1). The largest number (40%) originally hail from the Northeast, though with respect to their current residence, they are evenly distributed across the nation's four regions. Just over 50% come from a working class background, with the next largest group (32%) coming from an upper middle class family. The median age is 45.

As a group, the sample is predominantly liberal in political and religious orientation. At least in matters of religion there is a tendency to be less traditional than their parents. Twenty-five percent claim no religion, while only 2% were raised without it. Forty-four percent were born Protestant, 25% Jewish, and 18% Catholic. The most popular psychological orientation is psychoanalytic (39%) followed by behavioral (25%) and humanistic/existential (15%).

TABLE 1

Demographic and Ideological Traits of the Sample

Variable			
Sex	Male, 82%	Female, 18%	
Age	30-45, 50%	45-80, 50%	
Race	White, 96%	Black, 1.5%	Other, 2%
Religion	Prot, 33% None, 25%	Cath, 11% Other, 9%	Jew, 22%
Family relig	Prot, 44% None, 2%	Cath, 18% Other, 6%	Jew, 25%
Geog location	Northeast, 24% West, 28%	South, 26%	Midwest, 21%
Geog origin	Northeast, 40% West, 14%	South, 17%	Midwest, 28%
Psych orien	Analytic, 39% Other, 20%	Behav, 25%	Human/exis, 15%
Polit belief	Str lib, 14% Str con, 2%	Mod lib, 50% None, 3%	Mod con, 27% Other, 4%
Relig belief	Ath, 9% Mod lib, 24%	Ag, 22% Mod trad, 17%	Str lib, 17% Str trad, 6%
Class orig	Low, 7% Upper, 10%	Working, 51%	Upper mid, 32%
Sexual pref	Hetero, 93%	Bi-homo, 6.5%	

Factor Analysis on the CJS

As mentioned earlier, a 17-item Clinical Judgment Scale (CJS) first introduced by Wallach and Strupp (1960) was used in this study as the dependent variable. Factor analysis employing an oblique rotation on the CJS revealed that it could be divided into four distinct factors. Each item is reported to be on the factor it loaded the most highly with.

Factor 1

This factor, which explains 54% of the variance, can best be described as measuring the extent to which the therapist "likes the patient," and feels able to work with him effectively. It contains items 14-17:

14) Assuming that your recommendations for treatment were followed, how would you rate the prognosis for this patient? (Factor loading = .57).

15) How would you rate your willingness to accept this patient for treatment? (Factor loading = .77).

16) Do you find it easy or difficult to empathize with this patient? (Factor loading = .84).

17) How would you characterize your personal reaction to this patient? (Factor loading = .77).

That this one factor explained the majority of the variance is consistent with Wallach and Strupp's (1966) finding that

item 17 alone, personal reaction to the patient, was the best predictor of the overall CJS score.

Factor 2

This factor, explaining 25% of the variance, can best be described as measuring clinicians' estimates of patient "pathology" and corresponding need for treatment. It contains items 8, 10, 11, 12, and 13:

8) Considering the entire range of mental disorder, how would you characterize the degree of disturbance in this patient? (Factor loading = .33).

10) If this patient were accepted for psychotherapy, how would you rate the chances of his acting out? (Factor loading = .47).

11) How extensive a change in the patient's character structure would you attempt? (Factor loading = .60).

12) Assuming the patient did not terminate prematurely, about how long would you expect to see this patient? (Factor loading = .57).

13) Assuming no treatment were undertaken, how would you rate the prognosis for this patient? (Factor loading = .55).

Factor 3

This factor, explaining 10% of the variance, appears

to measure the amount of internal and external "stress" the clinician believes the patient is experiencing. It is composed of items 1 and 2.

1) How much anxiety does this patient seem to have? (Factor loading = .61).

2) How much environmental stress does this patient have to contend with? (Factor loading = .47).

Factor 4

This last factor, explaining 9% of the variance, seems to measure the degree of "psychological maturity," positive mental health or self-actualization the clinician believes the patient has attained. It contains items 3-7:

3) How much insight do you think this patient has into his problems? (Factor loading = .48).

4) How much motivation for therapy does this patient have? (Factor loading = .47).

5) How would you rate this patient's overall emotional maturity? (Factor loading = .73).

6) How would you characterize this patient's social adjustment? (Factor loading = .64).

7) How much "ego strength" does this patient seem to have? (Factor loading = .48).

Hypothesis 1

Hypothesis 1A. Patients described as holding an extreme ideological orientation will be rated more negatively than those who do not.

Using multivariate analysis of variance for repeated measures,[1] hypothesis 1A was confirmed on all four factors (see Tables 2 and 3). The ideological patients were rated more negatively than the non-ideological patients. Squared Pearson correlations between the ideology/no ideology condition and the significant dependent variables reveal that the ideology factor explains only between 1% and 2% of the variance.

Hypothesis 1B. Ideological patients will be assigned more severe diagnoses. Specifically, a) they will receive more axis II diagnoses and b) they will more often be diagnosed obsessive compulsive or compulsive personality disorder.

The ideological groups were not more often assigned axis II diagnoses. However, using chi square, it was found that the ideological patients were assigned the diagnosis of obsessive compulsive disorder almost three times as often as the non-ideological patients (see Figure 1) ($\chi^2 = 18.$, $df = 4$, $p \leq .001$). In contrast, the non-ideological patients were more often assigned the more mild generalized anxiety disorder

---

[1]Unless otherwise specified, all effects are tested by means of multivariate analyses of variance for repeated measures, and involve a main effect on interaction with "condition," the difference in the ratings assigned to ideological and non-ideological patients.

TABLE 2

Effect of Patient Ideology on Factors 1-4

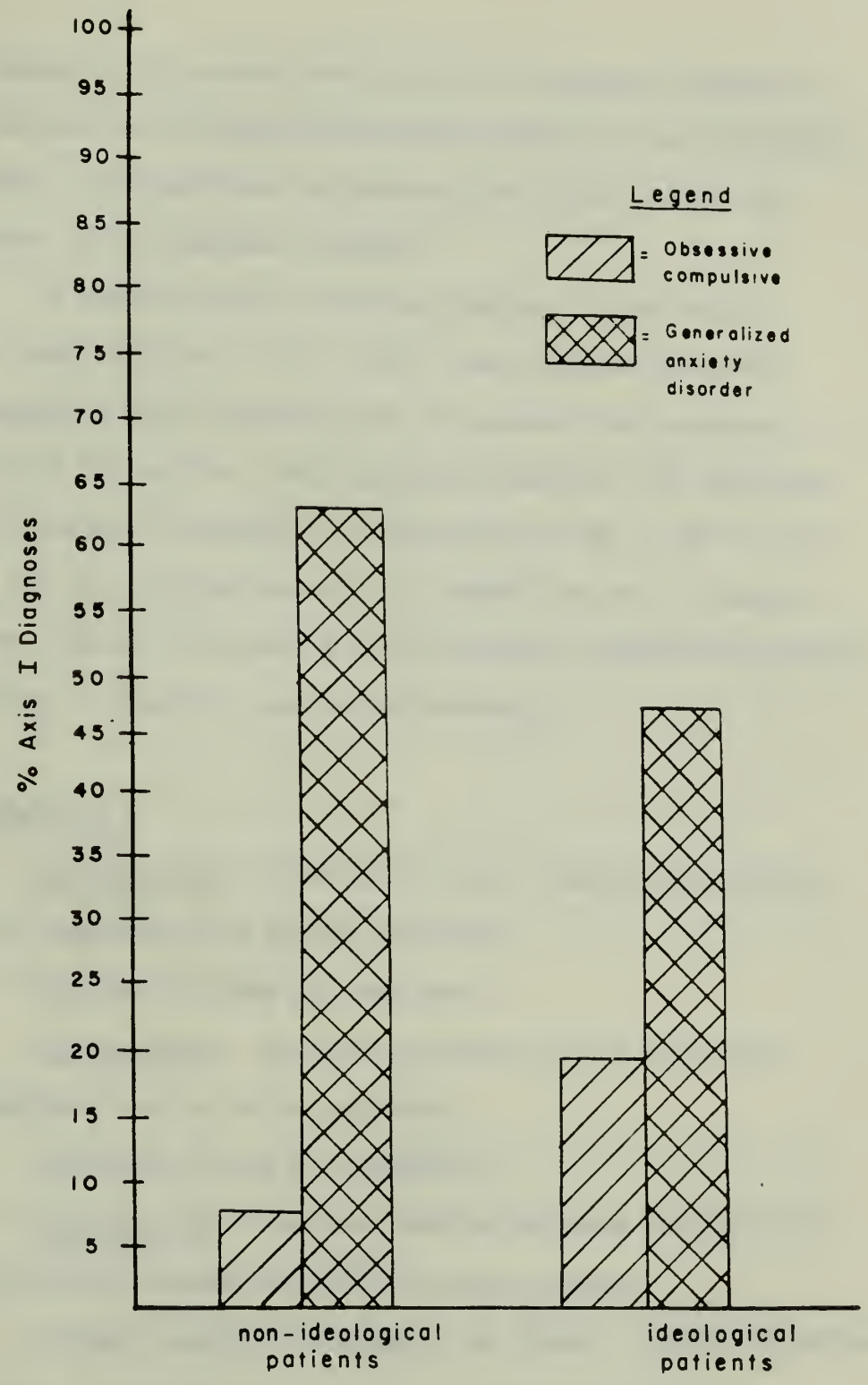
Factor	Multivariate		
	F	df	p
Like patient (1)	3.23	4, 323	$\leq .01$
Pathology (2)	3.01	5, 315	$\leq .05$
Stress (3)	4.94	2, 336	$\leq .01$
Maturity (4)	2.54	5, 323	$\leq .01$

TABLE 3

Effect of Patient Ideology on Individual Items

Factor	Item	F	df	p	r^2
1	Prognosis w trtmt	3.99	1, 326	$\leq .05$	.01
1	Accept for trtmt	7.12	1, 326	$\leq .01$	.01
1	Empathy for	12.17	1, 326	$\leq .001$	.02
1	Personal react	6.24	1, 326	$\leq .01$	.015
2	Length of trtmt	5.13	1, 319	$\leq .05$	.005
3	Anxiety	4.94	1, 336	$\leq .01$	.01
4	Maturity	9.20	1, 327	$\leq .01$	.015
4	Social adj	9.43	1, 327	$\leq .01$	.015

Figure 1. Ideological and non-ideological patients compared on percent of obsessive compulsive and generalized anxiety disorder diagnoses received.


100
95
90
85
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
% Axis I Diagnoses
Legend
= Obsessive compulsive
= Generalized anxiety disorder
non-ideological patients
ideological patients

diagnosis. It is worth noting that the obsessive compulsive diagnosis is very evenly distributed among the four ideological groups. No significant differences were found between the groups in the diagnoses received.

It should be noted that this finding, in particular, is specific to Mr. S who, overall, was diagnosed obsessive compulsive 20% of the time. Mr. W received that diagnosis only 2% of the time. When analyzed separately, the difference in diagnostic assignment is significant for Mr. S ($\chi^2 = 17.2$, $df = 4$, $p \leq .01$) but not Mr. W. Inasmuch as Mr. S evidences some symptoms consistent with the obsessive compulsive diagnosis, but Mr. W does not, this is not surprising.

Hypothesis 2

Hypothesis 2A. Subjects will rate conservative patients more negatively than liberal patients.

Hypothesis 2A was not confirmed.

Hypothesis 2B. Religious patients will be rated more negatively than political patients.

Hypothesis 2B was not confirmed.

Hypothesis 2C. The conservative religious patients will be rated more negatively than the other patients.

In fact, exactly the opposite was found. Planned comparisons revealed that subjects "liked" the conservative religious

patient better than the other three (see Figure 2)[2] (multivariate $F = 2.79$, $df = 4, 323$, $p \leq .05$). These results were found on all four of the items of the "like the patient" factor: "patient prognosis with treatment" ($F = 7.72$, $df = 1, 326$, $p \leq .01$); "desire to treat patient" ($F = 6.07$, $df = 1, 326$, $p \leq .01$); "empathy for patient" ($F = 7.35$, $df = 1, 326$, $p \leq .01$); and "personal reaction to patient" ($F = 6.76$, $df = 1, 326$, $p \leq .01$). Similar trends were noted on the "stress" ($p = .08$) and "maturity" ($p = .12$) factors.

These findings raise the question, "is the conservative religious patient, when analyzed alone, rated more negatively than the non-ideological patient? In fact, he is not different than the non-ideological patient on any of the four factors. Thus, the only dimension on which the conservative religious patient differs from the non-ideological patient is diagnosis (see Hypothesis 1B section).

Hypothesis 3

Hypothesis 3A. Liberal clinicians will rate conservative patients more negatively than liberal patients. Conservative clinicians will do the opposite.

This hypothesis was confirmed (see Figures 3 and 4) on

---

[2]In the interest of brevity, only the most significant item of a significant factor will be graphed, with the exception of hypothesis 3A, which was particularly complex. The dependent variable depicted is always the difference in ratings assigned the ideological and non-ideological patients.

Figure 2. Therapists compared on empathy for conservative religious patients vs. other ideological patients.

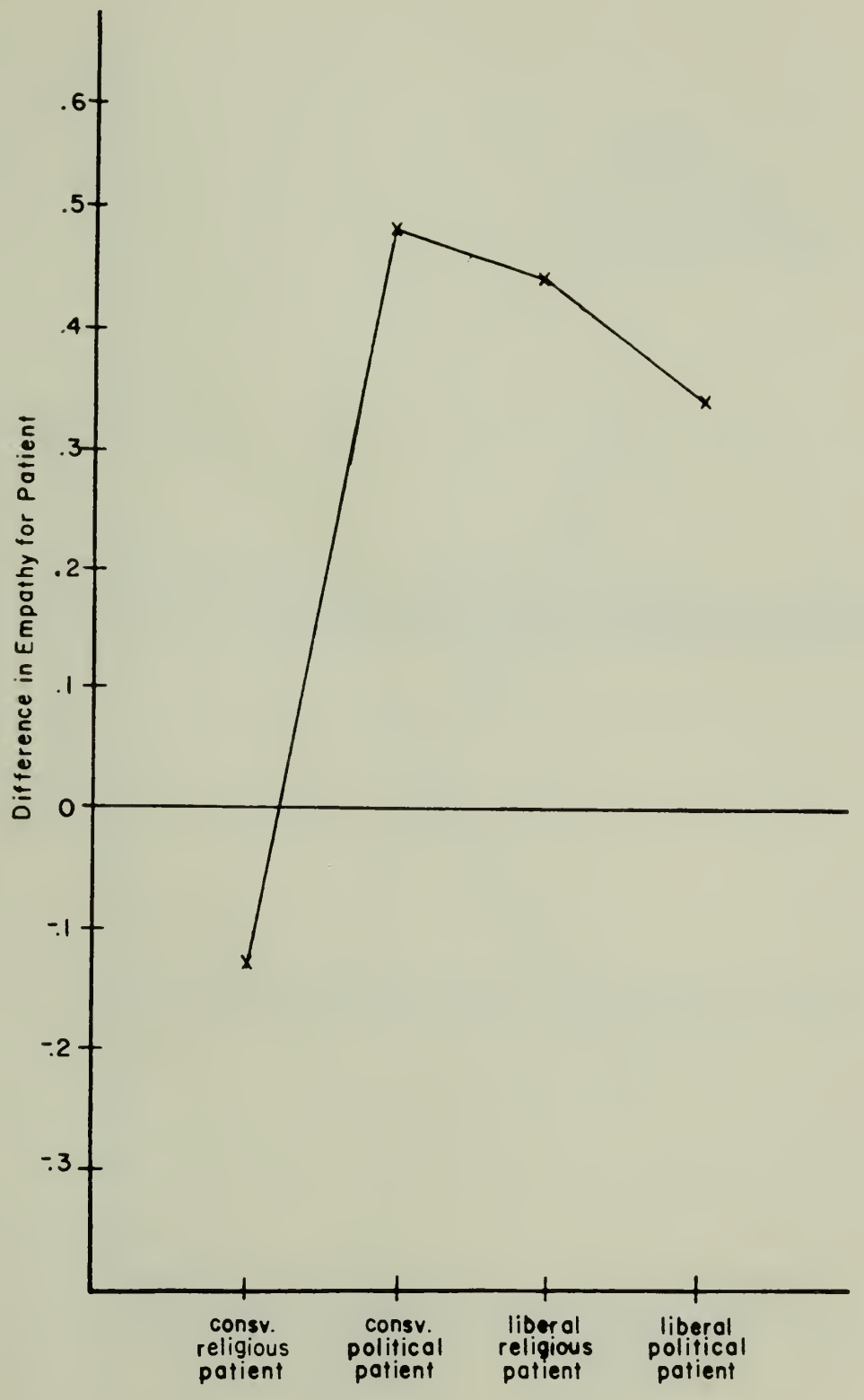

Difference in Empathy for Patient
.6
.5
.4
.3
.2
.1
0
-.1
-.2
-.3
consv. religious patient
consv. political patient
liberal religious patient
liberal political patient

Figure 3. Liberal and conservative therapists compared on empathy for liberal and conservative patients.

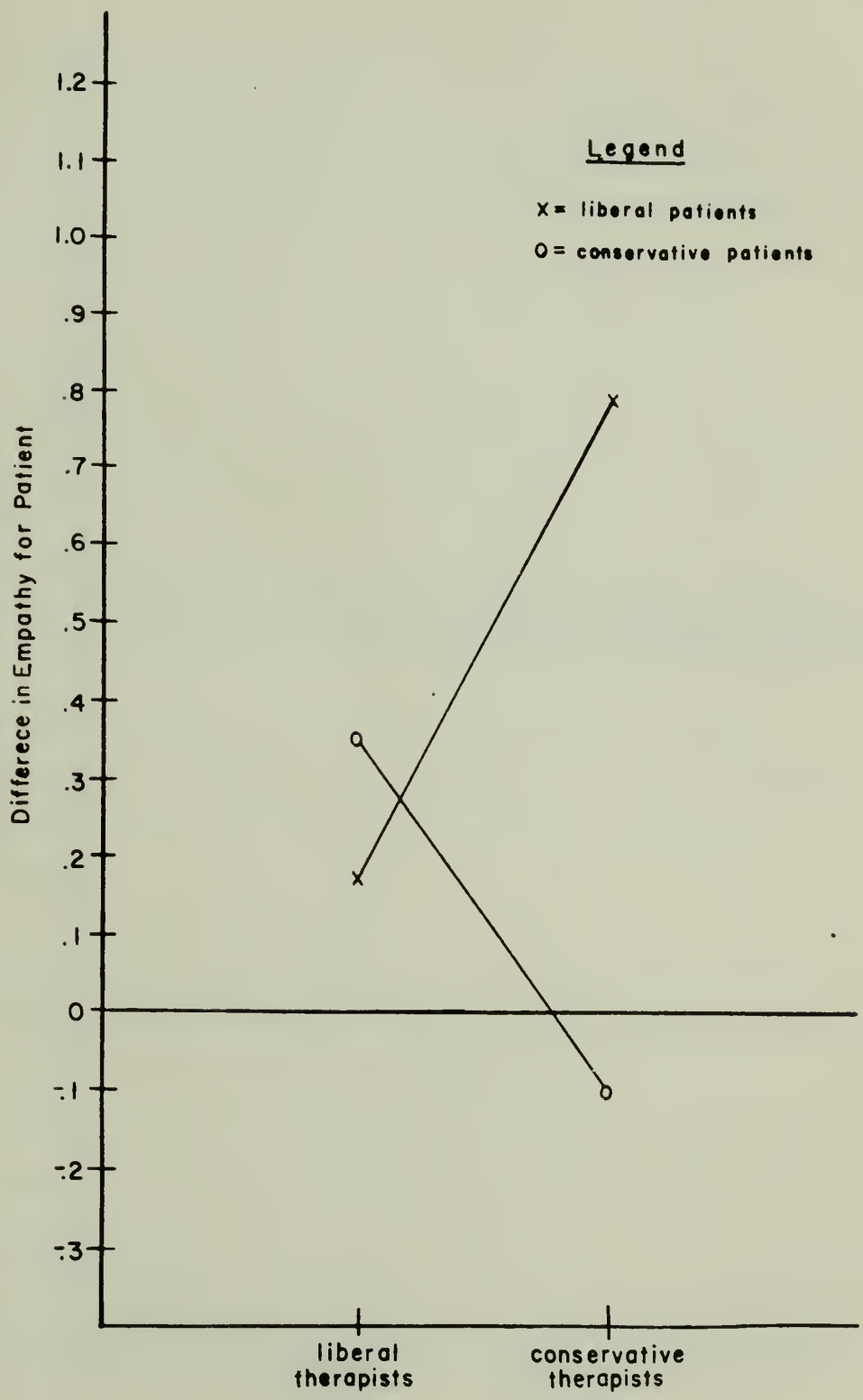
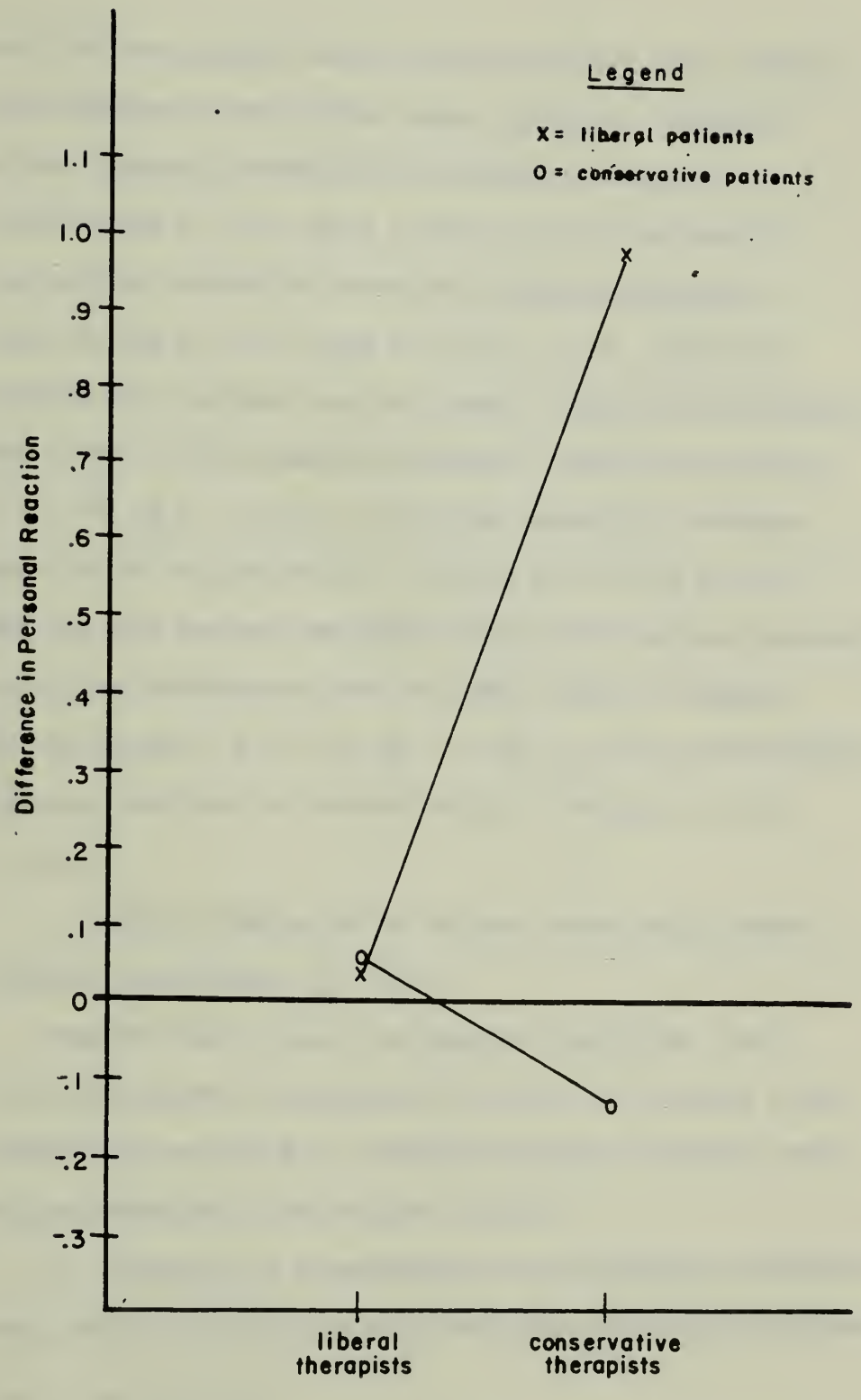

Legend
X = liberal patients
O = conservative patients
Differece in Empathy for Patient
1.2
1.1
1.0
.9
.8
.7
.6
.5
.4
.3
.2
.1
0
-.1
-.2
-.3
liberal therapists
conservative therapists

Figure 4. Liberal and conservative therapists compared on personal reaction to liberal and conservative patients.


Legend
X = liberal patients
O = conservative patients
Difference in Personal Reaction
1.1
1.0
.9
.8
.7
.6
.5
.4
.3
.2
.1
0
-.1
-.2
-.3
liberal therapists
conservative therapists

the "like the patient" factor when the patients were combined into conservative and liberal groups (therapist ideology X patient ideology X experimental condition interaction[3] (multivariate F = 4.31, df = 4, 274, $p \leq .01$) and when all four patient ideological groups were analyzed separately (multivariate F = 2.14, df = 12, 273, $p \leq .05$). When the patients were combined into two groups, significant differences were found on items measuring therapist "empathy for patient" (F = 8.74, df = 1, 279, $p \leq .005$) and therapist's "personal reaction" to the patient (F = 7.61, df = 1, 297, $p \leq .01$). When the four patient ideological groups were analyzed separately, significant differences were once again found on "empathy for the patient" (F = 7.76, df = 1, 297, $p \leq .01$) and therapist's "personal reaction" to the patient (F = 5.58, df = 1, 297, $p \leq .01$).

A parallel finding on the "stress" scale barely missed achieving significance (p = .06).

Figures 3 and 4 raise two important questions. Both are best answered by examining the results of this same 3-way interaction when the four ideological groups of patients were analyzed separately (see Figures 5 and 6).

1) Visually, it is undeniable that conservative therapists rate liberal patients more negatively than conservative patients.

---

[3]All subsequent effects are 3-way interactions unless otherwise specified.

Figure 5. Liberal and conservative therapists compared on empathy for CR, CP, LR and LP patients.

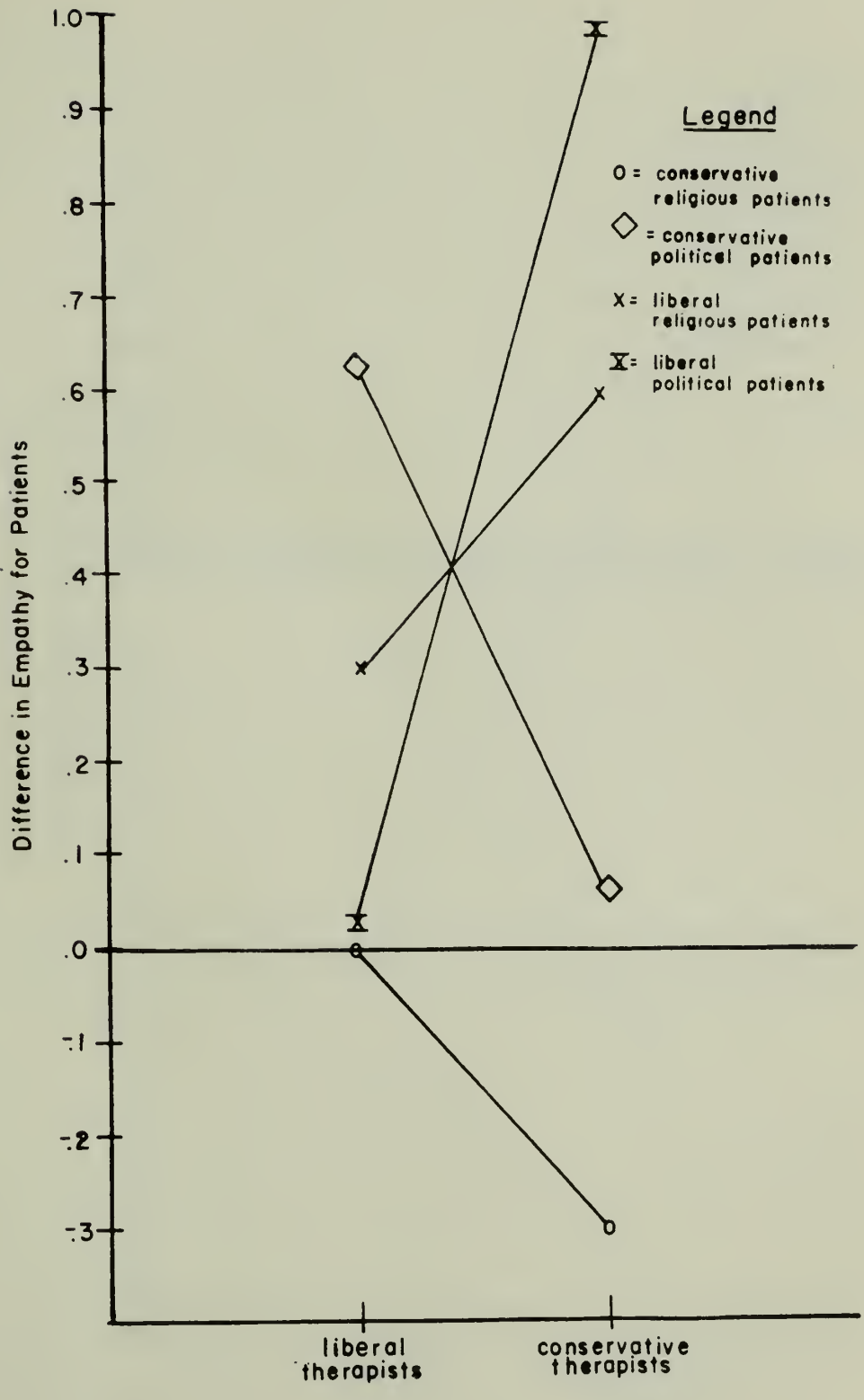
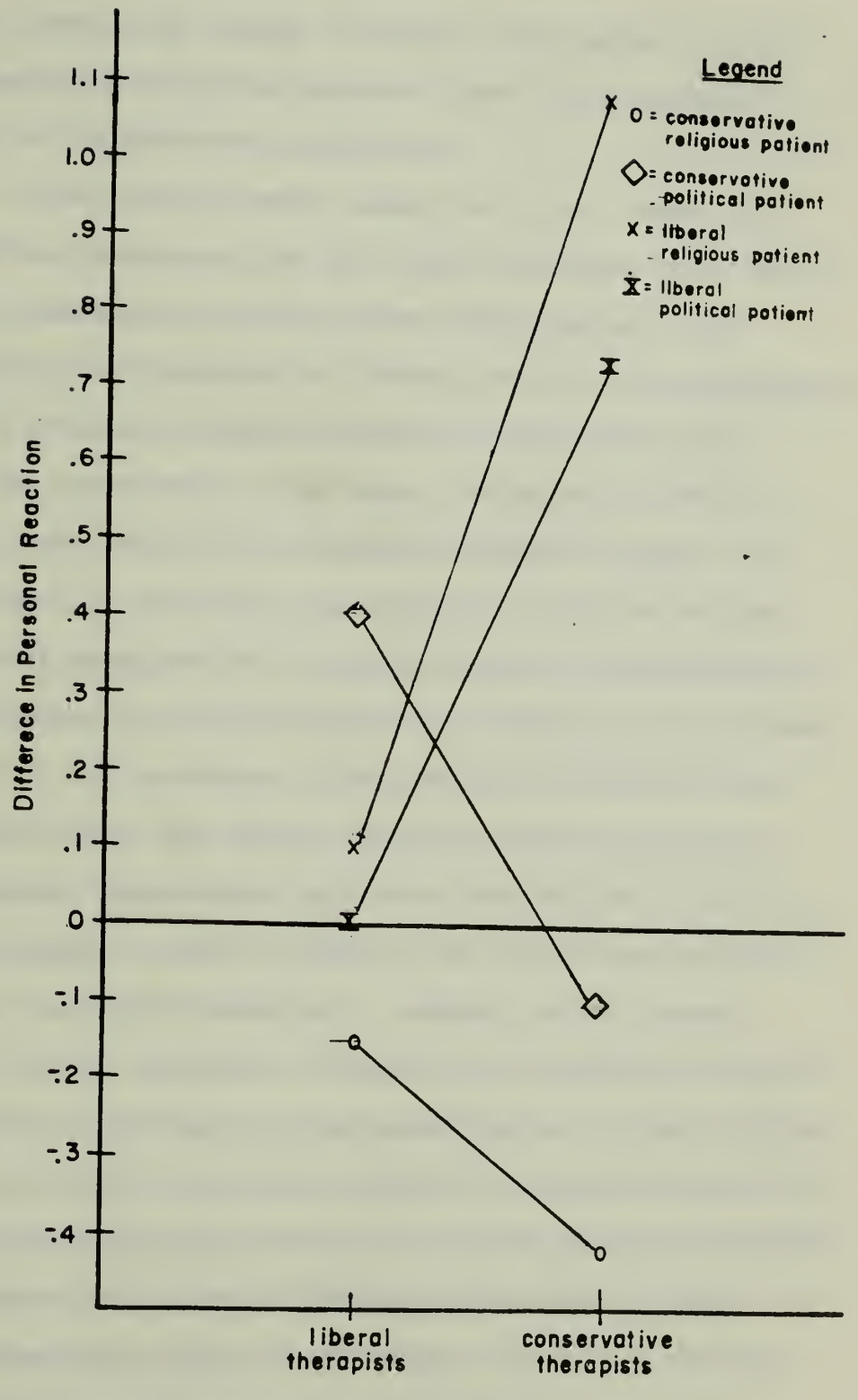

1.0
.9
.8
.7
.6
.5
.4
.3
.2
.1
.0
-.1
-.2
-.3
Difference in Empathy for Patients
Legend
O = conservative religious patients
◇ = conservative political patients
X = liberal religious patients
X = liberal political patients
liberal therapists
conservative therapists

Figure 6. Liberal and conservative therapists compared on personal reaction to CR, CP, LR and LP patients.


Legend
O = conservative religious patient
◇ = conservative political patient
X = liberal religious patient
X = liberal political patient
Difference in Personal Reaction
1.1
1.0
.9
.8
.7
.6
.5
.4
.3
.2
.1
0
-.1
-.2
-.3
-.4
liberal therapists
conservative therapists

Are liberals also biased? On Figure 3, they appear to rate conservative groups more negatively than liberal patients, but is this difference significant?

On balance, the answer appears to be yes. Newman-Keuls post-hoc comparisons find that liberal therapists do not rate the conservative religious patient more negatively than conservative therapists do. However, as we have already seen, this ideological group of patients is unique with respect to the other three. By and large, the sample as a whole is not biased against the conservative religious patients. By contrast, in the case of the conservative political patients, liberal therapists rate them more negatively than conservative therapists on both the "empathy" and "personal reaction" items.

2) Do conservative clinicians claim to dislike liberal patients more than liberal clinicians dislike conservative patients? Newman-Keuls comparisons were employed to answer this question as well. Figures 3 and 4 would seem to state that case rather dramatically. However, we must remember that liberal therapists' ratings of the conservative religious patient are averaged into the means depicted in those diagrams. The fact that liberals also dislike the conservative political patients less than conservative clinicians dislike both liberal groups on the "personal reaction" item (as well as to a nonsignificant degree on the "empathy" item) is an even more convincing confirmation of that hypothesis.

Thus, overall, we can conclude that conservative therapists express less tolerance for liberal patients than liberal clinicians express for conservative patients, though both prefer patients of their own persuasion.

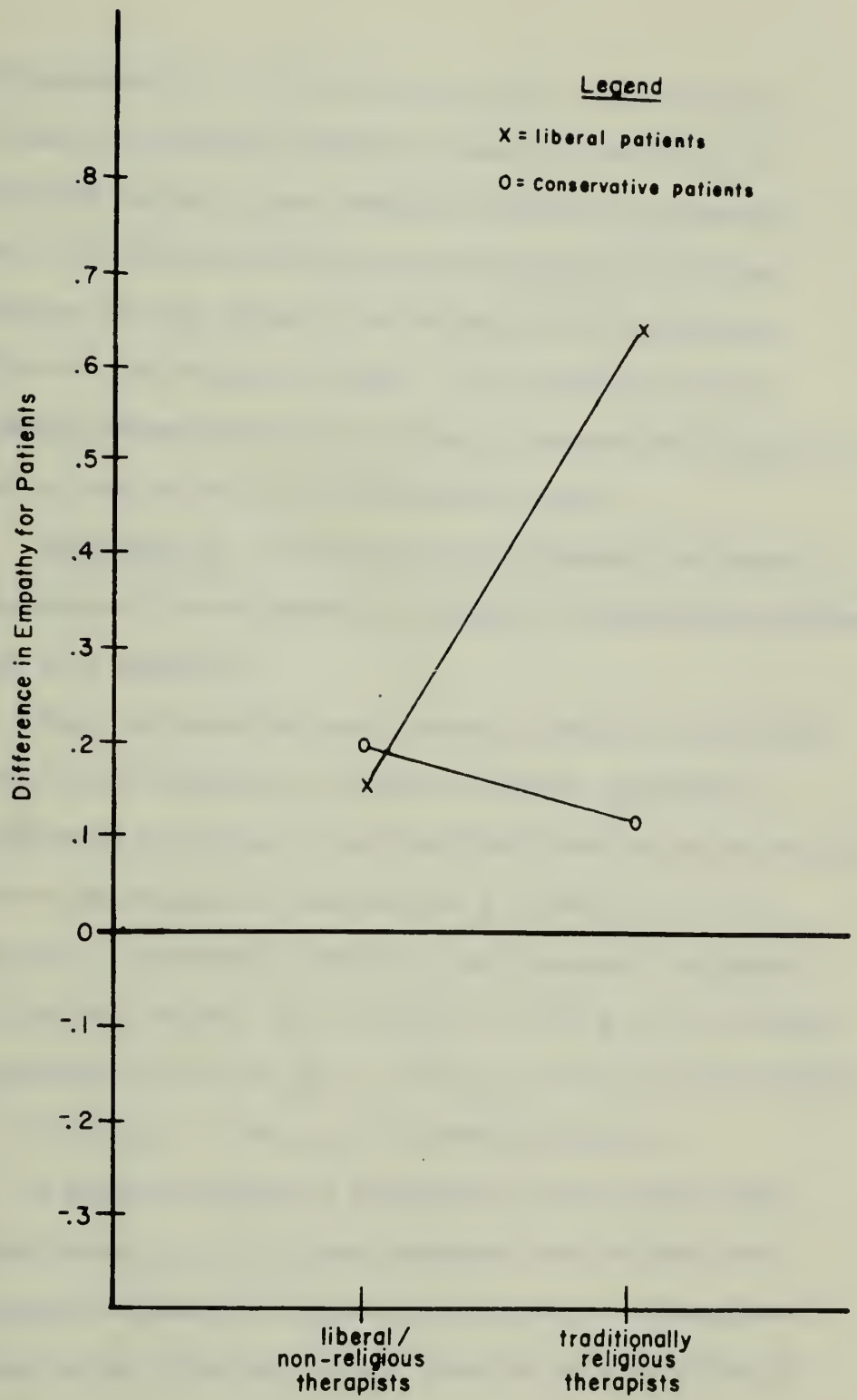
An unexpected additional finding, overall liberal clinicians rate all ideological patients as experiencing more stress than do conservative clinicians (therapist ideology X condition interaction: multivariate $F = 6.21$, $df = 2, 287$, $p \leq .01$). Findings were significant for both "patient anxiety" ($F = 6.24$, $df = 1, 288$, $p \leq .05$) and "environmental stress" ($F = 7.64$, $df = 1, 288$, $p \leq .01$).

Hypothesis 3B. Religious liberals and atheists will rate conservative groups more negatively than liberal groups. Traditionally religious clinicians will do the opposite.

Findings for this hypothesis are very similar to those found for political ideology. The hypothesis was confirmed for the "like the patient" factor (see Figure 7) (multivariate $F = 3.2$, $df = 4, 272$, $p \leq .05$). Significance was found on the "empathy for the patient" item ($F = 7.76$, $df = 1, 297$, $p \leq .01$) and "personal reaction" item ($F = 5.58$, $df = 1, 297$, $p \leq .01$). Further, if one examines Figure 7 and compares it to Figure 3, the results for therapist religious ideology are almost identical with those found for therapist political ideology.

As one might expect, political and religious ideology

Figure 7. Religiously liberal/non-religious and traditionally religious therapists compared on empathy for liberal and conservative patients.


Legend
X = liberal patients
O = conservative patients
Difference in Empathy for Patients
.8
.7
.6
.5
.4
.3
.2
.1
0
-.1
-.2
-.3
liberal / non-religious therapists
traditionally religious therapists

are correlated (r = .33, N = 329, $p \leq .01$). When both are included in a multiple regression equation, the effect of religious ideology almost completely drops out, suggesting that it is religious ideology's association with political ideology or some unknown third variable which explains its effect on the dependent variable. The political match or mismatch between patient and therapist accounts for 1.5% of the variance on the "like the patient" factor.

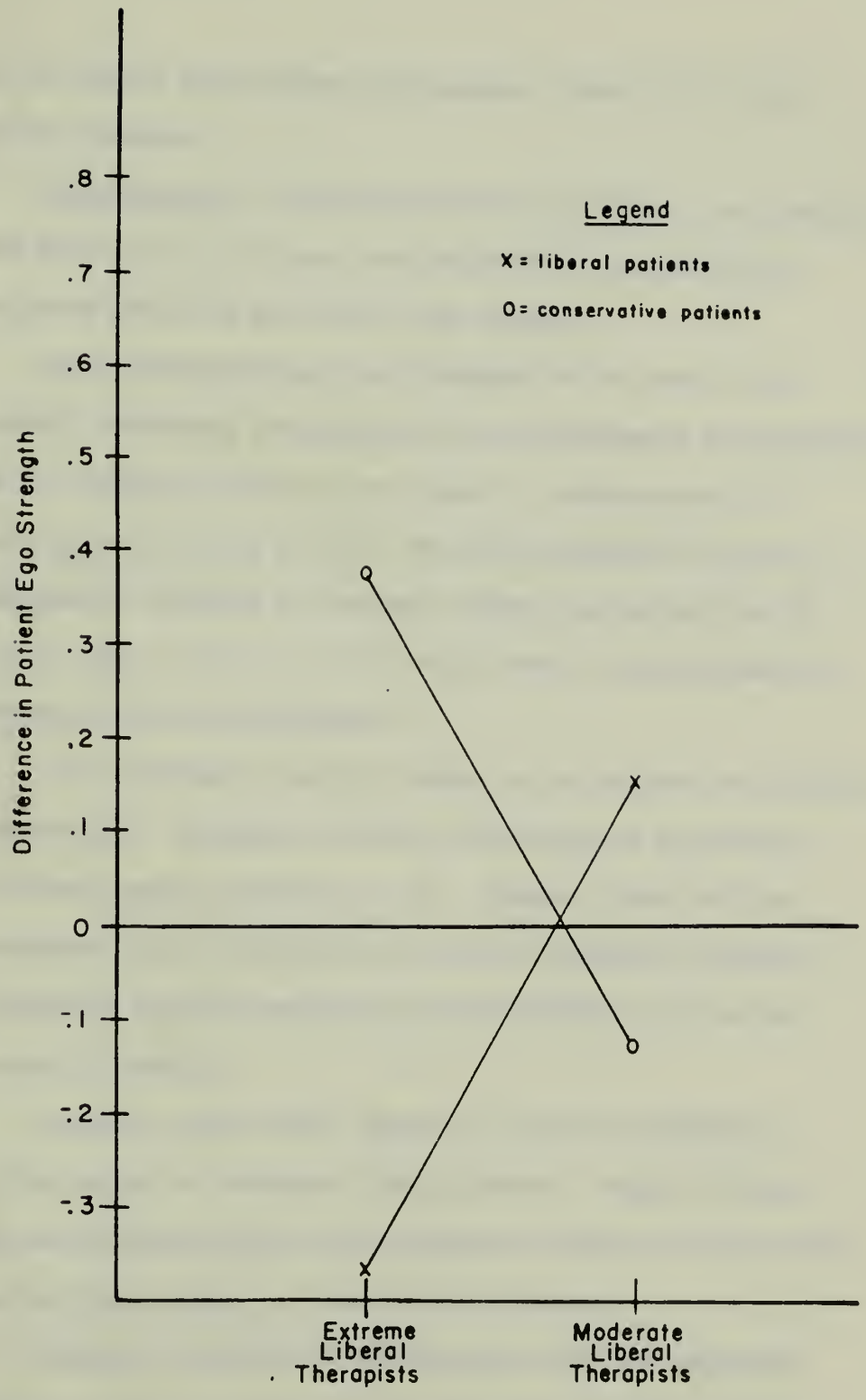
Hypothesis 3C. Clinicians who hold extreme ideological positions will rate patients with opposite beliefs more negatively than will moderates.

When therapists who were "strongly liberal" in political matters were compared to "moderate liberals" significant differences were found in the predicted direction on the maturity factor (see Figure 8) (multivariate F = 2.69, df = 5, 92, $p \leq .05$). Individual items measuring therapists' estimates of "patient insight" (F = 3.93, df = 1, 196, $p \leq .05$), "social adjustment" (F = 4.58, df = 1, 196, $p \leq .01$), and "ego strength" (F = 6.89, df = 1, 196, $p \leq .01$) were significant.

A parallel finding on the maturity scale barely missed significance (p = .052) when therapists were divided into religious liberals vs. atheists and agnostics. Trends were found on the "like the patient" scale for both political (p = .08) and religious ideology (p = .12).

Unfortunately, there were so few extreme conservatives

Figure 8. Extreme and moderate liberal therapists compared on estimates of patient ego strength for liberal and conservative patients.


Legend
X = liberal patients
O = conservative patients
Difference in Patient Ego Strength
.8
.7
.6
.5
.4
.3
.2
.1
0
-.1
-.2
-.3
Extreme Liberal Therapists
Moderate Liberal Therapists

in the sample that extreme and moderate conservatives could not be compared.

Hypothesis 3D. Clinicians from the Northeast, and possibly the West Coast, will react more negatively to conservative patients than will the rest of the country.

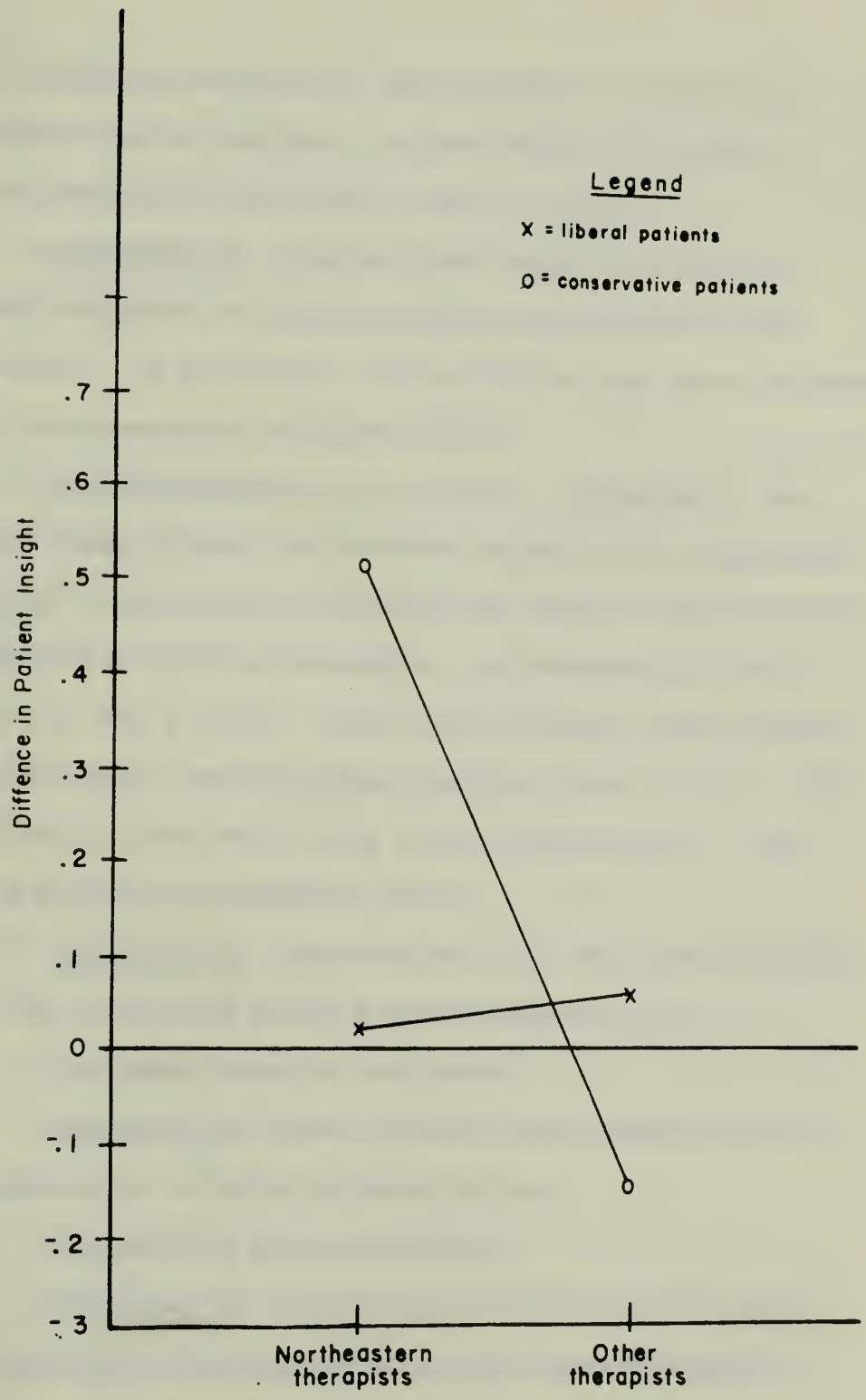
When Northeasterners were compared to the rest of the country (including the West Coast), the hypothesis was supported on the "maturity" factor (see Figure 9) (multivariate F = 2.45, df = 5, 317, $p \leq .05$). The only significant item was therapists' estimate of how much insight the patient had (F = 4.22, df = 1, 321, $p \leq .05$), with trends on motivation for therapy and social adjustment.

It is unlikely that this effect is an artifact of political orientation. Geographic location and political orientation do show a small correlation (.14). However, when both are introduced into a hierarchical multiple regression equation, geographic location explains the most variance (2%) on the "maturity" factor.

Moreover, this effect appears to also be independent of the strong vs. moderate liberal effect. Strong liberals, who were found to differ from moderate liberals on this factor, are not more likely to live in the Northeast.

Finally, one need not be concerned that the geography finding may be an artifact of the fact that CAPS therapists, who tend to be conservative, live predominantly outside of

Figure 9. Northeastern and other therapists compared on estimates of patient insight for liberal and conservative patients.


Legend
X = liberal patients
O = conservative patients
Diffence in Patient Insight
.7
.6
.5
.4
.3
.2
.1
0
-.1
-.2
-.3
Northeastern therapists
Other therapists

the Northeast (see pg. 83). When the CAPS therapists are removed from the analysis, the same results are obtained (multivariate $F = 2.55$, $df = 5, 281$, $p \leq .05$).

Hypothesis 3E. Jews will rate conservative patients more negatively and liberal patients more positively than Gentiles. In particular, Jews and Gentiles may appear different on the conservative religious patient.

This hypothesis was not confirmed. Unexpectedly, Jews were found to react less adversely overall to the ideological groups than Gentiles on the "like the patient" factor (therapist religion X condition interaction: multivariate $F = 3.44$, $df = 4, 288$, $p \leq .01$). None of the individual items achieved significance, though "personal reaction" almost did ($p = .055$). A similar trend which barely missed significance ($p = .056$) was found on the "maturity" factor.

Hypothesis 3F. Psychoanalysts will react more negatively to the ideological patients than will behaviorists.

Hypothesis 3F was not confirmed.

Hypothesis 3G. Women will react more favorably to the conservative religious patients than men.

Hypothesis 3G was not confirmed.

Hypothesis 3H. Homosexual clinicians will react more negatively to conservative patients and more positively to liberal patients than will heterosexual clinicians.

On the "stress" factor a trend in the predicted direction

was found ($p = .079$). The "patient anxiety" item was significant ($F = 5.09$, $df = 1, 326$, $p = .02$) and the "environmental stress" item was not significant. The two-way therapist sexual preference X patient ideology interaction, however, was significant (multivariate $F = 3.38$, $df = 2, 325$, $p \leq .05$) (see Figure 10).

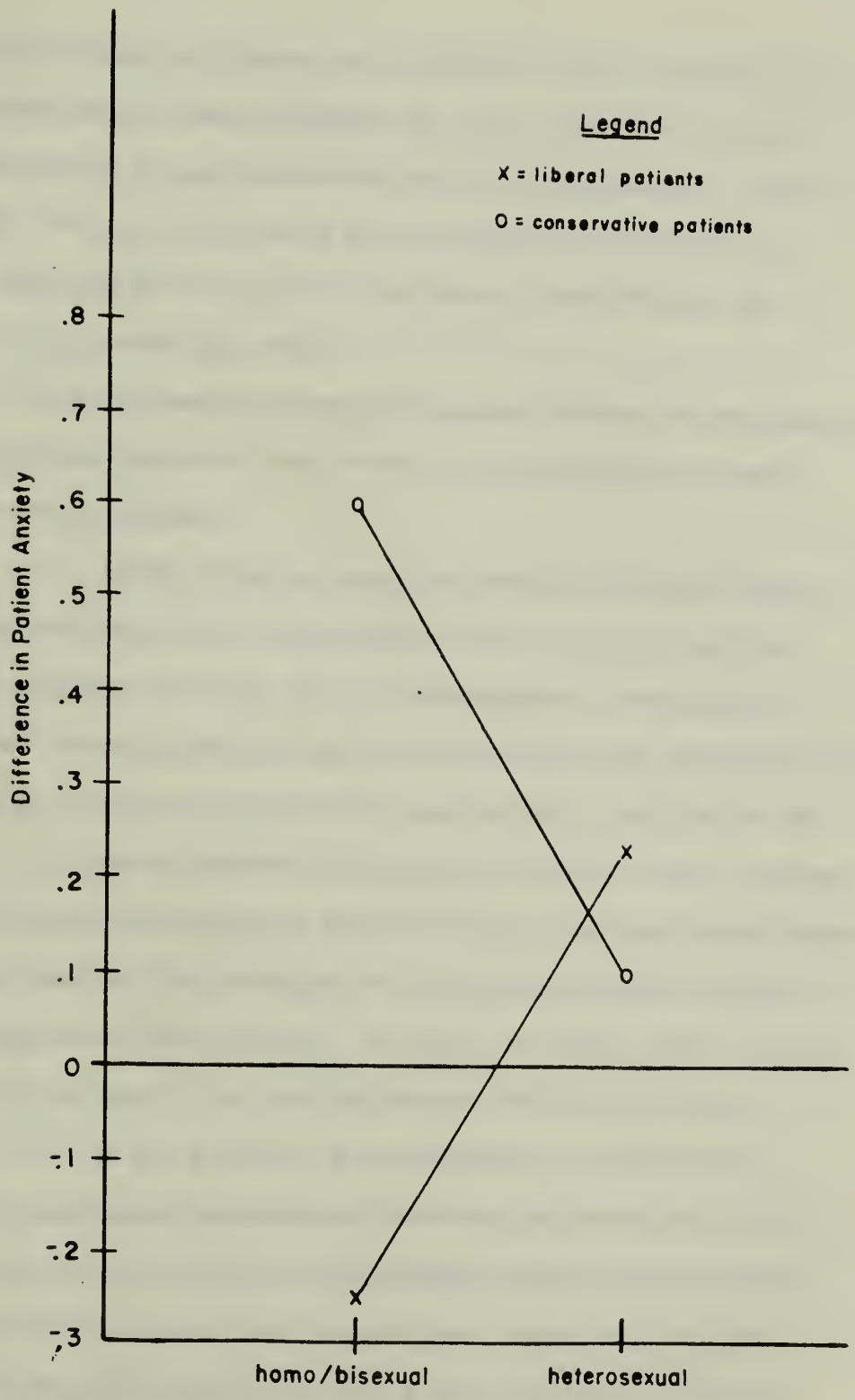
Exploratory Questions

No relationship was found between the age or social class of origin of the clinicians and their responses. There were too few minorities in the sample to assess the impact of race.

Mr. S Compared to Mr. W

The effort to find two perfectly matched cases was less than completely successful. Overall, Mr. S, the black graduate student presenting problems of stuttering, social anxiety and perfectionism, was seen more positively than was the white college student presenting unstable relationships, depression and familial conflict ($F = 12.2$, $df = 4, 673$, $p \leq .001$). Hotelling's T^2 reveals that Mr. S scores more positively on the "like the patient" factor ($F = 12$, $df = 4, 673$, $p \leq .001$) and the "pathology" factor ($F = 47.9$, $df = 5, 663$, $p \leq .001$). However, Mr. S is seen as experiencing significantly more internal and external stress ($F = 56$, $df = 2, 689$, $p \leq .001$).

Figure 10. Homosexual/bisexual and heterosexual therapists compared on estimates of patient anxiety for liberal and conservative patients.


Legend
X = liberal patients
O = conservative patients
Difference in Patient Anxiety
.8
.7
.6
.5
.4
.3
.2
.1
0
-.1
-.2
-.3
homo/bisexual
heterosexual

On the "maturity" factor, Mr. S and Mr. W split, with Mr. S being seen as less insightful (t = 3.71, df = 676, $p \leq .001$) and having a less satisfactory social adjustment (t = 2.54, df = 676, $p \leq .01$), while Mr. W is seen as less mature (t = 6.81, df = 676, $p \leq .001$) and lower in ego strength (t = 6.96, df = 676, $p \leq .001$).

The discovery of these differences between the two case histories raises at least three potential problems relevant to other analyses:

1) If Mr. S and Mr. W are not evenly distributed among the ideological and nonideological cases, results could be an artifact of the Mr. S/Mr. W distribution. Fortunately, this is not a problem. Mr. S and Mr. W are very evenly distributed (e.g., 51% of the ideological cases are Mr. S and 49% Mr. W).

2) The differences between Mr. S and Mr. W will increase the error term making it more difficult to achieve significance and lowering the percentage of variance accounted for by the experimental manipulation. In fact, the effect sizes in this study are small, and this may be one contributing factor.

3) If Mr. S and Mr. W are different, it may be that the experimental manipulation does not influence the ratings given to both of them. When analyzed alone, the ideological patients are rated significantly more negatively than the nonideological patient for Mr. S (F = 1.9, df = 16, 306, $p \leq .05$) but not for Mr. W. However, though they fail to achieve

significance, each of the 16 items is in the expected direction and item 5, patient maturity, is significant (t = 2.91, df = 333, $p \leq .01$). Therefore, though it is clear that the effect is stronger for one patient, the fact that both consistently achieve results in the same direction seems an adequate basis for combining them in subsequent analyses, though caution will need to be applied when discussing the generalizability of these findings.

CAPS and National Register Therapists Compared

Before combining the CAPS and National Register samples, they were compared for possible differences. As one might expect, chi square reveals that CAPS therapists are much more likely to be Protestant (χ^2 = 62, df = 4, $p \leq .0001$), from a Protestant background (χ^2 = 48, df = 4, $p \leq .0001$), religiously traditional (χ^2 = 112, df = 6, $p \leq .0001$), and politically conservative (χ^2 = 58, df = 6, $p \leq .0001$). CAPS clinicians were also more likely to live in the West or Midwest and less likely to live in the Northeast than National Register psychologists (χ^2 = 10.9, df = 4, $p \leq .05$). They were less likely to originate from the Northeast as well (χ^2 = 4.8, df = 1, $p \leq .05$).

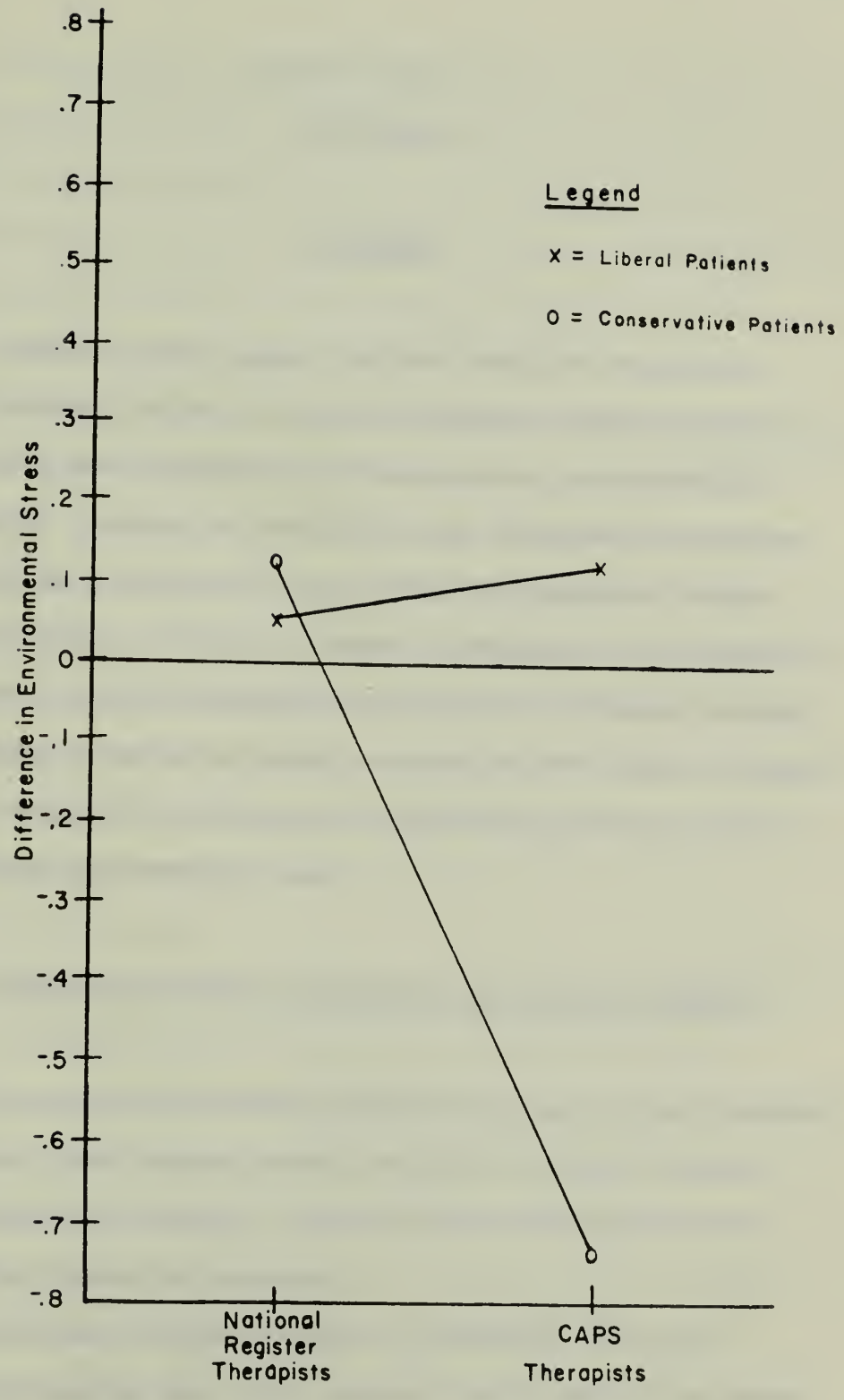
When the four ideological patients are combined into two groups, conservative patients and liberal patients, CAPS

therapists were found to rate conservative patients lower on the stress factor than National Register therapists (see Figure 11) (professional organization X patient ideology X condition interaction: multivariate $F = 3.88$, $df = 2, 342$, $p \leq .05$). This difference is almost exclusively explained by the difference between CAPS and National Register therapists on the "environmental stress" item ($F = 7.27$, $df = 1, 343$, $p \leq .01$).

Surprisingly, the CAPS clinicians rated all of the ideological groups lower than the National Register sample on the "maturity" factor (professional organization X condition interaction: multivariate $F = 4.08$, $df = 5, 329$, $p \leq .01$). The only significant item on this factor was "patient maturity" ($F = 12.85$, $df = 1, 333$, $p \leq .001$).

No differences were found on the other factors or the diagnoses assigned to patients.

Figure 11. National Register and CAPS therapists compared on estimates of patient environmental stress for liberal and conservative patients.


.8
.7
.6
.5
.4
.3
.2
.1
0
-.1
-.2
-.3
-.4
-.5
-.6
-.7
-.8
Difference in Environmental Stress
Legend
X = Liberal Patients
O = Conservative Patients
National Register Therapists
CAPS Therapists

CHAPTER V

DISCUSSION

Overview

Overall, strong support has been found for the notion that patients holding an extreme ideological orientation are perceived more negatively by clinicians than non-ideological patients. Contrary to predictions, the conservative religious patient was the exception rather than the preeminent example of this effect. Finally, a number of demographic and ideological factors, including therapists' political and religious ideology, geographic location and sexual orientation were found to interact with therapists' evaluations of ideological patients in both predicted and unexpected ways.

Extreme Ideological Orientations and Clinical Judgment

The extreme ideological patients were seen as more disturbed, immature, under greater stress, and were less liked than the non-ideological patients. They were also more likely to be diagnosed obsessive-compulsive.

Are these findings evidence of prejudice? This is a complex question about which arguments could be made for either side.

If one wanted to argue the affirmative position, he or she would simply need to point to this study's findings. When all other factors are held constant, clinicians rate a patient with an extreme ideological orientation more negatively than a non-ideological patient on all four factors. On the face of it this seems to be a clear indication of bias. Yet, in fairness, a number of mitigating factors need be considered.

First, to put this finding in perspective, it should be noted that the effect size was quite small, explaining no more than 2% of the variance. This suggests that while the patient's ideological orientation influenced clinicians' judgments, it was a relatively small influence. This is a strong contrast to unabashedly negative ratings college students give to these same groups (Gartner, in progress). Psychologists indeed may distinguish themselves more by their tolerance than their prejudice.

Furthermore, these results were strongest for one patient, Mr. S, a black graduate student who manifested a number of compulsive symptoms. Further research may show that particular patient demographics and traits are more likely to elicit a negative response to patient ideology, rather than it being a simple "across the board bias." Further research is needed to determine how generalizable these findings are. (It is a matter of speculation as to what in Mr. S elicited a stronger response. His race may make an extreme ideological position

appear more unusual, or his compulsive symptoms may be more consistent with clinicians' negative expectations concerning the psychological function of extreme ideological systems.)

Secondly, there is a rational basis for making negative judgments about these groups. Some research has found that people with extreme right wing and extreme left wing views are less well adjusted than the general population (Eysenck & Coulter, 1972; Kreml, 1977; Rokeach, 1960). In particular, research has found such individuals to be more dogmatic. Though there is not room for a full review here, dogmatism has been correlated with just about everything under the sun over the last twenty years, from cognitive rigidity (Rokeach, 1960) to paranoia (Eysenck & Coulter, 1972), and the consensus is that it is better not to be dogmatic.

The critic pressing for the prejudice theory would, of course, seek to rebut these arguments. He or she would argue that a "small bias" is still a bias. (In addition, we don't really know how small the bias is since psychologists may be trying to appear nonprejudiced.) Further, the existence of a rational or statistical basis for bias does not necessarily justify it. For example, it is well known that women as a group have been found to perform more poorly than men on mathematical tests. (Conversely, men are worse on verbal tests.) Would it be fair or reasonable for science oriented graduate schools to rank female applicants lower than males

on the basis of these statistical norms? Finally, it is relevant to note that the strength of the relationships between group membership and most negative traits is rarely as strong as people perceive them to be (Hamilton, 1981). Patients with extreme ideological orientations may not be as sick as clinicians think.

The proponents of these two views could probably continue their debate. However, we can end this section with a conclusion they would both most likely agree on. Whether or not a negative preliminary evaluation of an ideological patient is an expression of prejudice, it certainly does not bode well for the future therapeutic relationship.

In an important study, Hans Strupp (1958) showed therapists a film of a clinical interview. At key moments the film was stopped and the subject played the role of therapist. Strupp found that:

> Therapists who indicated a dislike for the patient tended to choose more pejorative diagnostic labels, such as psychopath, paranoid or character disorder. They also saw the patient as less insightful, more immature, and having a poor prognosis. They anticipated encountering certain kinds of problems in treatment, such as countertransference feelings of anger or resentment. These therapists were more inclined to be strict, active and to suggest a briefer and more supportive type of therapy which might be terminated by unworkable countertransference reactions. Their interventions were rated as colder and less empathic [three times as often].... [This study] clearly demonstrates that a clinician's initial impressions and

> feelings about a patient can strongly and adversely affect his clinical work. (Singer & Luborsky, 1977, pg. 442-443)

Past research (Berzins, 1977; Beutler, 1972) has demonstrated that a high degree of value discrepancy between patient and therapist is a poor prognostic indicator for therapy. The current findings suggest that the therapist's initial negative reaction to patients who differ from them ideologically may be an important factor in that effect.

The encouraging finding is that Strupp (1958) reports that therapists who had themselves been analyzed were less likely to be cold to patients they did not like, the implication being that therapists who are more advanced, introspective or conflict-free can overcome their personal reactions well enough to provide quality services to the disliked patient. If nothing else, the current study should alert us as clinicians to the potential problem of ideological countertransference, and allow us to take appropriate steps to minimize its negative impact on our clinical work.

Religious Prejudice in Psychology?

This study has not provided great support for the notion that psychologists' clinical judgments are biased against conservative religious patients. The Christian fundamentalist patient was not rated more negatively than the non-ideological

patient on any of the four factors. These results are consistent with those reported by Lewis (1983) who, in a similar study, found no bias against a depressed evangelical who used religious language during an interview. In addition, the conservative religious patient in this study was rated more positively than the other three ideological groups.

It is unfortunate that there is no empirical research on this problem before 1983. Though it is pure speculation, I suspect the same results might not have been obtained twenty or thirty years ago. Rather, this greater tolerance toward religion may be a more recent development, the product of at least three separate developments.

First, over the last twenty years, the field has become increasingly sensitive to biases of all kinds among mental health professionals (Abramowitz & Dokecki, 1974). Secondly, there seems to have been a change specifically in the attitudes of mental health professionals toward religion. While early psychologists and psychiatrists expressed their negative views toward religion with little apology or opposition (see Gartner, 1982), a more recent trend toward a rapprochement between psychology and religion has been noted by several authors (Bergin, 1983; Pattison, 1969; Saffady, 1976). Parallel to this change in psychologists' attitudes toward religion has been a change in the character and general public perception of conservative religious groups. Fundamentalists, with some

justification, were often perceived as reactionary, rigid, anti-intellectual, legalistic, and separatistic. However, more recently, a new group, whom Quebedeaux (1974) has called the "Young Evangelicals," has emerged. They are theologically conservative, but as a group more educated, moderate and mainstream in their beliefs and lifestyles. The prime example is former president Jimmy Carter, who probably did the most to alert the American public that not all Evangelicals fit the old Fundamentalist stereotype.

Thus, a greater tolerance for religion as well as a greater sophistication about the general problems of bias and the diversity of religious people may have contributed to these findings. Psychologists may choose to understand their individual patient's religious faith in greater depth before pre-judging it. These results should be encouraging to those religious people who fear entering psychotherapy because they believe therapists are hostile to religion (King, 1978).

This is not to suggest that a conservative religious orientation has no influence on clinicians' perceptions of clients. It was found that the conservative religious patient was more likely to be given the diagnosis of obsessive compulsive, in contrast to the non-ideological patient who was more likely to be diagnosed generalized anxiety disorder. Obsessive compulsive disorder is generally considered to be both more severe and unusual than generalized anxiety disorder (American Psychiatric

Association, 1980). Thus, it is difficult to explain why the conservative religious patient was not rated more negatively on the Clinical Judgment Scale. It is possible that subjects inflated their ratings of the conservative religious patient in an effort not to appear prejudiced (who could better decipher the purpose of a psychological experiment than a psychologist?).

It is also possible that the patient's religion may influence therapists' clinical judgments in a fashion which is more qualitative than quantitative. Rather than causing them to see the patient as more disturbed, it changes the way in which they understand his disturbance. Freud (1913) argued 70 years ago that religion is an obsessive compulsive neurosis. Clinicians appear to still be influenced by that view today. (It should, however, also be noted that effect was almost exclusively specific to one patient who manifested some symptoms consistent with the obsessive compulsive diagnosis. Thus, the mere religious label alone is not sufficient to elicit the obsessive compulsive diagnosis.) More research into qualitative differences in how clinicians conceptualize cases involving religious patients seems called for.

The next question is why were the other three ideological groups perceived so much more negatively than the conservative religious patient? While there may be more than one possible explanation, the most plausible appears to be that the conservative religious group is substantially more frequent in the American

population. One in three Americans claims to be a Born-Again Christian (Princeton Religious Research, 1982) whereas the number of John Birch Society, Atheist International and Socialist party members is likely to be no more than 1% of the population. This probably represents an error in the experimental design, though perhaps a serendipitous one. An effort was made to balance the groups, at least subjectively, with respect to extremism, but no attention was paid to statistical frequency.

Thus, ideological belief systems which are both extreme and rare may be the most likely to be perceived as deviant by clinicians. In fact, one of the most commonly taught models of psychological deviance is the statistical model (Kleinmuntz, 1980), which states the simple thesis that the unusual is deviant. Little research has been done on the extent to which the statistical model actually affects clinicians' day-to-day clinical judgments.

Overall, these results suggest that the question of religious prejudice in psychology is a complex one. The appropriate question may not be "does religious bias exist?" but among which psychologists, against which groups, under which circumstances? For instance, Gartner (1982) found that professors of clinical psychology were less likely to admit a Born-Again Christian into clinical psychology graduate school than an identical non-ideological applicant. It may be that clinicians are less tolerant of ideological diversity among potential

colleagues than among patients. The statistical model of deviance may help explain this finding as well. While one out of five Americans, and therefore we can assume a substantial number of patients, are traditionally religious (Princeton Religious Research Center, 1982), only one in 25 psychologists is religiously traditional (Nix, 1978; this study). Thus, religious therapists are statistically deviant while religious patients are not. Further research into this "professional bias" is planned by this author. In addition, there is as of now little psychotherapy process research that examines the religious variable. Indeed, it may be some time before we have a complete picture of clinicians' attitudes toward religion.

The Effect of Therapists' Demographic and Ideological Traits

Political Ideology

Both liberal and conservative clinicians were found to like patients better whose ideologies were closer to their own. Conservative therapists disliked liberal patients more than conservative patients and liberal clinicians disliked conservative patients (not including the conservative religious patient) more than liberal patients. Further, this effect appears stronger the more extreme the therapist's ideology is, and therefore, the larger the ideological gulf between

therapist and patient.

Past research (Ehrlich, 1973) has shown that most people like people who are ideologically consistent with themselves better than other people who are not. In this sense, clinicians are perhaps only demonstrating that they are human. It is an important and happy finding that clinicians did not change their judgments of patient pathology or maturity on the basis of the ideological match between themselves and the patient, though the effect on the stress factor failed to achieve significance by only a narrow margin.

Probably the most important conclusion we can draw from these results is that many therapists should carefully consider before seeing patients whose ideologies are sharply different from their own. At the very least, clinicians should be sensitive to the potential problem of ideological countertransference. This may be particularly important for therapists who themselves hold extreme beliefs. As was mentioned earlier, these findings illuminate one key factor that may contribute to the lower success rate therapists have with patients whose values differ strongly from their own (Berzins, 1977; Beutler, 1972). Therapists may begin liking such patients less from the beginning, making the formation of an effective therapeutic alliance difficult.

Overall, conservative clinicians dislike liberal patients more than liberal clinicians dislike conservative patients. The most ready explanation is simply that conservatives may

be more prejudiced than liberals, which is consistent with past research (Simpson & Yinger, 1972). However, this finding may be best understood in the context of another one: liberals see all ideological groups as being higher in stress than do conservative therapists. These two findings may reflect differences at the heart of liberal and conservative ideology.

In some ways it could be said that liberals believe more in a process than a creed when compared to conservatives. Stated simplistically, liberals seem to believe more in the importance of letting the human mind and spirit develop unimpeded, in the faith that that process will lead to knowledge and human growth. For that reason, the American Civil Liberties Union is more concerned with preserving political freedom (even for Nazis) than in proposing a particular political platform, and some liberal psychologists are as concerned about whether a patient's mind is open and flexible as they are about its contents. In contrast, conservatives may be more concerned with the preservation of a particular set of ideas, essential truths (e.g., the centrality of the family), which are not necessarily viewed as appropriate subjects for debate.

If the above analysis is correct, it is not surprising that liberals overall view extreme ideological orientations more negatively than conservatives. Such orientations limit the experimentation and curiosity which the liberal cherishes

by demanding adherence to a particular viewpoint. The extreme ideologue may be seen as experiencing more stress either because his or her orientation is seen as a "cheap" solution to the ambiguity of life and intolerable personal stress, or because the orientation itself is seen as restrictive and therefore stress inducing.

In contrast, the conservative appears to be more offended by ideas which differ from his or hers in content, which would be consistent with the conservative's concern for a particular set of beliefs.

Religious Ideology

Findings for this variable were virtually identical to those obtained for political ideology. Indeed, political and religious ideology were correlated and explained the same portion of variance. Political ideology appeared to explain slightly more variance, causing it to nudge religious ideology out of the multiple regression equation. While political ideology seems a bit more salient, it appears that there may be an overall liberal/conservative continuum, on which therapists can be divided, which incorporates both political and religious ideology. If that were the case, we would expect to find parallel results for both variables as we have indeed found.

Geography

Northeastern clinicians perceive extreme conservative patients to be more immature than extreme liberal patients, whereas this is not true of therapists who live in other regions.

The statistical model of deviance may again be of use here. Extreme conservatives are more infrequent in the Northeast. For example, the Princeton Religious Research Center (1982) found almost every other Southerner to be an Evangelical Christian, but only one in 11 Northeasterners were found to hold such beliefs. Thus, the statistical model would predict that Northeastern clinicians would rate extreme conservative groups more negatively. (Inasmuch as Northeastern conservatives have chosen a belief system which is more unusual to their region, it is at least conceivable that research may find them to be more disturbed than conservatives in the rest of the country.)

These findings suggest that the anti-conservative discrimination which this author expected to find in this data may be peculiar to the Northeast. (Not coincidentally, many of the observations which led the author to hypothesize such a bias exists were based on the author's experience as a Northeastern doctoral student in clinical psychology.) Northeastern clinicians may need to take special care in attending to the problem of anti-conservatism.

CAPS Members

CAPS members perceive conservative patients as experiencing less stress than liberal patients. This may be indicative of a general bias in favor of the conservative patients, which is consistent with findings concerning religious ideology reported earlier (indeed, CAPS members show results in the appropriate direction on the "like the patient" factor).

Two qualifying observations are worth noting, however. First, CAPS members do not rate liberal patients as experiencing more stress than do therapists from the National Register. They are expressing a positive bias in favor of the conservative patients, but not a corresponding negative one toward the liberals. Secondly, this effect is almost completely specific to the item measuring environmental stress, which is very unusual. That particular item was rarely significant in other analyses. Though it is only a speculation, one wonders if these traditionally religious therapists, familiar with the close-knit communities that grow up around churches, are inferring that patients who belong to such traditional organizations have a stronger than average support system.

CAPS members also rated all the ideological groups as more immature than did the rest of the sample. There may be a hint here, as in the findings for therapist religious ideology, of the link between religiosity and prejudice (Simpson & Yinger, 1972) which has been reported in the general population.

It may also be that CAPS therapists, by virtue of their own ideological commitment, are more sensitive to subtle variations in extreme ideological orientations. (Indeed, many of the articles published in the journals which publish articles of concern to CAPS members focus on distinguishing between "mature" and "immature" faith.) For instance, most CAPS therapists would most likely notice that the conservative religious patient was described as a "Fundamentalist." Within Christian circles, the label "Fundamentalist" is often sharply contrasted to the less reactionary "Evangelical" (Quebedeaux, 1974), whereas many outsiders might not know the difference.

More generally, these results may be another example of therapists who themselves hold an extreme ideological orientation, being more reactive than moderate therapists to the ideological belief system of their patients. Such therapists would be well advised to devote special attention to their potentially negative reactions toward patients whose ideologies differ from their own.

Sexual Orientation

Homosexual and bisexual clinicians perceive conservative patients as experiencing more stress, particularly anxiety, than liberal patients, and perceive conservative patients as experiencing more stress than heterosexual clinicians do.

Conservative groups have long held negative (some would

argue persecutory) attitudes toward homosexuality and homosexuals. It is, thus, not surprising to find that homosexual clinicians perceive conservative patients negatively. One wonders if the homosexual clinicians are projecting some of their own feelings about conservative groups onto their patients.

The conservative patient may make the homosexual clinician anxious, or, putting himself in the patient's place, the homosexual clinician may imagine that if he or she were a conservative, or lived in a conservative subculture, it would be very personally stressful.

In any case, the same note of caution that has been sounded to other groups concerning the danger of ideological countertransference should be extended to homosexual clinicians who may have extreme conservative patients.

Religion

Jews were found to be more tolerant than Gentiles of ideological groups, an intriguing finding. Jews may be more sensitive to intolerance, as a consequence of being victimized by it. However, inasmuch as those victimizers were often fueled by extreme ideologies, Jews' greater tolerance of such people is surprising. These results are at variance with previous findings (Gartner, 1982) which showed Jews to react more negatively than Gentiles to a Born-Again Christian applicant to graduate school in clinical psychology. Clearly, more

research into this variable is called for.

REFERENCES

Abramowitz, C. V., & Dokecki, P. R. (1977). The politics of clinical judgment: Early empirical returns. Psychological Bulletin, 84, 460-476.

Abramowitz, S. I., Abramowitz, C. V., Jackson, C., & Gomes, B. (1973). The politics of clinical judgment: What non-liberal examiners infer about women who do not stifle themselves. Journal of Consulting and Clinical Psychology, 41, 385-391.

Abramowitz, S. I., Roback, H. B., Schwartz, J. M., Yasuna, A., Abramowitz, C. V., & Gomes, B. (1976). Sex bias in psychotherapy: A failure to confirm. American Journal of Psychiatry, 133, 706-709.

Adorno, T. W., Frankel-Brunswick, E., Levinson, D. J., & Sanford, R. N. (1950). The authoritarian personality. New York: Harper & Row.

Ajzen, I., & Fishbein, M. (1977). Attitude-behavior relations: A theoretical analysis and review of empirical research. Psychological Bulletin, 84, 888-918.

American Psychiatric Association (1980). Diagnostic and statistical manual of mental disorders (DSM-III). Washington, DC: Author.

Argyle, M., & Beit-Hallahmi, B. (1975). The social psychology of religion. Routledge, Keegar & Paul.

Becker, R. J. (1971). Religion and psychological health. In M. Strommen (Ed.), Research on religious development: A comprehensive handbook. New York: Hawthorn.

Bergin, A. (1980). Psychotherapy and religious values. Journal of Consulting and Clinical Psychology, 48, 95-105.

Bergin, A. (1983). Religiosity and mental health: A critical reevaluation and meta-analysis. Professional Psychology, 14, 170-184.

Berzins, J. I. (1977). Therapist-patient matching. In A. Gorman & A. Razin (Eds.), Effective psychotherapy. Oxford, England: Pergamon Press.

Beutler, L. E. (1971). Predicting outcomes of psychotherapy: A comparison of predictions from two attitude theories. Journal of Consulting and Clinical Psychology.

Beutler, L. E. (1972). Value and attitude change in psychotherapy: A case for dyadic assessment. Psychotherapy: Theory, Research and Practice, 9, 362-367.

Blake, W. (1973). The influence of race on diagnosis. Smith College Studies in Social Work, 43, 184-192.

Braginsky, B. M., & Braginsky, D. D. (1974). Mainstream psychology: A critique. New York: Holt, Rinehart & Winston.

Broverman, I., Broverman, D., Clarkson, F., Rosenkrantz, P., & Vogel, S. (1970). Sex role stereotypes and clinical judgments of mental health. Journal of Consulting Psychology, 34, 1-7.

Burdock, E. V., Cheek, F., & Zubin, J. (1960). Predicting success in psychoanalytic training. In P. Hoch & J. Zubin (Eds.), Current approaches to psychoanalysis. New York: Grune & Stratton.

Chesser, E. (1956). The sexual, marital and family relationships of English women. London: Hutchinson.

Cook, T. E. (1966). The influence of client-counselor value similarity on change in meaning during brief counseling. Journal of Counseling Psychology, 13, 77-81.

Dittes, J. E. (1971). Religion, prejudice and personality. In M. Strommen (Ed.), Research on religious development: A comprehensive handbook. New York: Hawthorn.

Dyer, D. T., & Luckey, E. B. (1961). Religious affiliation and selected personality scores as they relate to marital happiness of Minnesota College sample. Marriage and Family Living, 23, 46-47.

Ehrlich, D., & Weiner, D. N. (1961). The measurement of values in psychotherapeutic settings. Journal of General Psychology, 64, 359-372.

Ehrlich, H. (1973). The social psychology of prejudice. New York: Wiley.

Ellison, C. W., & Paloutzian, R. I. (1979, August). Religious experience and quality of life. Paper presented at the meeting of the American Psychological Association, New York.

Eysenck, H. J., & Coulter, T. T. (1972). Journal of Social Psychology, 87, 59-73.

Farson, R. E. (1961). Introjection in the psychotherapeutic relationship. Journal of Counseling Psychology, 8, 337-343.

Freud, S. (1913). Totem and taboo. Standard edition, 13, 1-161. London: Hogarth Press.

Garfield, S., & Bergin, A. (1978). Handbbook of psychotherapy and behavior change. New York: Wiley.

Gartner, J. (1981, April). Anti-biblical value biases in psychological testing: The Personal Orientation Inventory. Paper presented at the meeting of the Christian Association for Psychological Studies, San Francisco.

Gartner, J. (1982, August). Christians need not apply: Religious discrimination in clinical psychology graduate school admissions. Paper presented at the meeting of the American Psychological Association, Washington, DC.

Gartner, J. (1983). Self-esteem tests: Assumption and values. In C. Ellison (Ed.), Your better self. New York: Harper & Row.

Gartner, J. (in progress). Ideological stereotypes and social distance among college students.

Gerrard, N. L. (1965). The serpent-handling religions of West Virginia. Trans-action, May.

Glock, C. Y., & Stark, R. (1965). Religion and society in tension. Chicago: Rand McNally.

Goldsmith, W. M. (1983). Rememberances of data past: A review of the Journal's empirical research, 1973-1982. Journal of Psychology and Theology, 11, 11-19.

Goldsmith, W. M., & Harrig, D. (1978, June). Glossalalia and internal-external locus of control: A replication. Paper presented at the Western Association of Christians for Psychological Studies, Malibo, CA.

Goldsmith, W. M. J., & Sandborn, B. D. (1982, August). Religiosity and the "guilty personality": A control study. Paper presented at the meeting of the American Psychological Association, Washington, DC.

Goldstone, M. G. (1971). Differences in prognosis for psychotherapy as a function of client race (Doctoral dissertation, Purdue University, 1971). Dissertation Abstracts International, 31, 4992B-4993B.

Gomes, B., & Abramowitz, S. I. (1976). Sex-related patient and therapist effects on clinical judgment. Sex Roles, 2, 1-13.

Gorman, A. S., & Razin, A. M. (Eds.). (1977). Effective psychology. Oxford, England: Pergamon Press.

Gorsuch, R. L., & Aleshire, D. (1974). Christian faith and ethnic prejudice: A review and interpretation of research. Journal for the Scientific Study of Religion, 3, 281-308.

Hamilton, D. (Ed.) (1981). Cognitive processes in stereotyping and intergroup behavior. Hillsdale, NJ: Lawrence Erlbaum Associates.

Hogan, R., & Emler, N. (1978). The bias in contemporary social psychology. Social Research, 45, 478-534.

Hollingshead, A., & Redlich, F. (1958). Social class and mental illness. New York: Wiley.

Holzman, M. S. (1962). The significance of value systems of patient and therapist for outcome of psychotherapy. Dissertation Abstracts International, 22, 4073.

Katz, D., & Braly, K. (1933). Racial stereotypes of 100 college students. Journal of Abnormal and Social Psychology, 13, 1-16.

Kessel, P., & McBrearty, J. F. (1967). Values and psychotherapy: A review of the literature. Perceptual and Motor Skills, 25, 669-690.

King, R. (1978). Evangelical Christians and professional counseling: A conflict of values? Journal of Psychology and Theology, 6, 276-281.

Kleinmuntz, B. (1980). Essentials of abnormal psychology. New York: Harper & Row.

Koppel, I., & Farina, A. (1971). Hospitalization time and psychiatrists' perception of mental patients. Journal of Clinical Psychology, 27, 59-61.

Kreml, W. P. (1977). The anti-authoritarian personality. Oxford, England: Pergamon Press.

Landfield, A. W., & Nawas, M. M. (1964). Psychotherapeutic improvement as a function of communication and adoption of therapists' values. Journal of Counseling Psychology, 11, 336-341.

Landis, J. T., & Landis, M. G. (1953). Building a successful marriage. Englewood Cliffs, NJ: Prentice Hall.

Levy, M., & Kahn, M. (1970). Interpreter bias on the Rorschach test as a function of patient's socioeconomic status. Journal of Projective Techniques and Personality Assessment, 34, 106-112.

Lewis, K. (1983, August). Impact of religious affiliation on therapists' judgment of clients. Paper presented at the meeting of the American Psychological Association, Anaheim, CA.

London, P. (1964). The modes and morals of psychotherapy. New York: Holt, Rinehart & Winston.

McClintock, C., Spaulding, L., & Turner, H. (1965). Political orientations of academically affiliated psychologists. American Psychologist, 20, 211-221.

Martin, C., & Nichols, R. C. (1962). Personality and religious belief. Journal of Social Psychology, 56, 3-8.

Masling, J., & Harris, S. (1969). Sexual aspects of TAT administration. Journal of Consulting and Clinical Psychology, 33, 166-169.

Meehl, P. E. (1959). Some technical and axiological problems in the therapeutic handling of religious and valuational material. Journal of Counseling Psychology, 6, 255-259.

Morris, C., Eidvson, B., & O'Donovan, D. (1960). Values of psychiatric patients. Behavioral Science, 5, 297-312.

Myers, J., & Schaeffer, L. (1954). Social stratification and psychiatric practice: A study of an outpatient clinic. American Sociological Review, 19, 307-310.

Nawas, M. M., & Landfield, A. W. (1963). Improvement in psychotherapy and the adoption of the therapist's meaning system. Psychological Reports, 13, 97-98.

Nix, V. (1978). A study of the religious values of psychotherapists. Unpublished doctoral dissertation, New York University.

Parloff, M. B., Iflund, B., & Goldstein, N. (1960). Communication of "therapy values" between therapist and schizophrenic patients. Journal of Nervous and Mental Disorders, 130, 193-199.

Patterson, C. H. (1959). Counseling and psychotherapy: Theory and practice. New York: Harper & Row.

Pattison, E. M. (Ed.) (1969). Clinical psychiatry and religion. Boston: Little, Brown.

Petony, P. (1966). Value change in psychotherapy. Human Relations, 19, 39-46.

Pettit, I. B., Pettit, T. F., & Welkowitz, J. (1974). Relationship between values, social class and duration of psychotherapy. Journal of Consulting and Clinical Psychology, 42, 482-490.

Princeton Religious Research Center (1982). Religion in America. Princeton, NJ: Author.

Quebedeaux, R. (1974). The young evangelicals. New York: Harper & Row.

Rabkin, J. G. (1977). Therapists' attitudes toward mental illness and health. In A. Gurman & A. Razin (Eds.), Effective psychotherapy. Oxford, England: Pergamon Press.

Roche Laboratories (1974). Report of a survey of psychiatric opinion on a social issue--'Women's Liberation.' Psychiatric Viewpoints Report. Nutley, NJ: Hoffman LaRoche.

Rokeach, M. (1960). The opened and closed mind. New York: Basic Books.

Rosenbaum, M., Friedlander, J., & Kaplan, S. M. (1956). Evaluation of results of psychotherapy. Psychosomatic Medicine, 18, 113-132.

Rosenthal, D. (1955). Changes in some moral values following psychotherapy. Journal of Consulting Psychology, 19, 431-436.

Saffady, W. (1976). New developments in the psychoanalytic study of religion: A bibliographic review of the literature since 1960. The Psychoanalytic Review, 63, 291-299.

Sanua, V. D. (1969). Religion, mental health and personality: A review of empirical studies. American Journal of Psychiatry, 125, 1203-1213.

Sattler, J. M. (1977). The effects of therapist-client racial similarity. In A. Gurman & A. Razin (Eds.), Effective psychotherapy. Oxford, England: Pergamon Press.

Schlossberg, N. K., & Pietrofesa, J. J. (1973). Perspectives on counseling bias: Implications for counselor education. Counseling Psychologist, 4, 44-54.

Schofield, W. (1964). Psychotherapy: The purchase of friendship. Englewood Cliffs, NJ: Prentice Hall.

Simpson, G. E., & Yinger, J. M. (1972). Racial and cultural minorities: An analysis of prejudice and discrimination. New York: Harper & Row.

Singer, B. A., & Luborsky, L. (1977). Countertransference: The status of clinical vs. quantitative research. In A. S. Gurman & A. M. Razin (Eds.), Effective psychotherapy. Oxford, England: Pergamon Press.

Siskind, G. (1973). Sexual aspects of Thematic Apperception Test administration. Journal of Consulting and Clinical Psychology, 40, 20-21.

Spilka, B., & Goldsmith, W. M. (1981). Faith and behavior: Religion in introductory psychology texts of the 1950's and 1970's. Teaching of Psychology, 8, 158-160.

Spilka, B., & Werme, P. H. (1971). Religion and mental disorder: A research perspective. In M. Strommen (Ed.), Research on religious development: A comprehensive handbook. New York: Hawthorn.

Stanley, G. (1963). Personality and attitude characteristics of fundamentalist theological students. Australian Journal of Psychology, 15, 121-123.

Stanley, G. (1964). Personality and attitude correlates of religious conversion. Journal for the Scientific Study of Religion, 4, 60-63.

Stanley, G., & Vagg, P. (1975). Attitude and personality characteristics of Australian Protestant Fundamentalists. Journal of Social Psychology, 96, 291-292.

Stark, R. (1971). Psychopathology and religious commitment. Review of Religious Research, 12, 165-176.

Stein, L., Green, B., & Stone, W. (1972). Therapist attitudes as influenced by A-B therapist type, patient diagnosis and social class. Journal of Consulting and Clinical Psychology, 39, 301-307.

Strong, S. R. (1978). Social psychological approach to psychotherapy research. In S. Garfield & A. Bergin (Eds.), Handbook of psychotherapy and behavior change. New York: Wiley.

Strupp, H. (1958). The psychotherapists' contribution to the treatment process. Behavioral Science, 3, 34-67.

Strupp, H. (1963). The outcome problem in psychotherapy revisited. Psychotherapy: Theory, Research and Practice, 1, 1-13.

Szasz, T. S. (1974). The myth of mental illness. New York: Harper & Row.

Tellegen, A., Gerrard, N. L., Gerrard, L. B., & Butcher, J. M. (1967). Personality characteristics of members of a serpent-handling religious cult. In J. N. Butch (Ed.), MMPI: Research developments and clinical applications. New York: McGraw Hill.

Thomas, T. S., & Stewart, N. R. (1971). Counselor response to female clients with deviate and conforming career goals. Journal of Counseling Psychology, 18, 352-357.

Truax, C. B. (1966). Reinforcement and nonreinforcement in Rogerian psychotherapy. Journal of Abnormal Psychology, 71, 1-9.

Van Leeuwen, M. S. (1982). The sorcerer's apprentice. Downers Grove, IL: Intervarsity Press.

Vitz, P. (1977). Psychology as religion: The cult of self-worship. Grand Rapids, MI: Eerdmons.

Vitz, P. (1982a). Kholberg's scale of moral development. The New Oxford Review.

Vitz, P. (1982b). A Christian critique of academic personality theory. Journal of Ongoing Formation, 3, 263-282.

Wallach, M., & Strupp, H. (1960). Psychotherapists' clinical judgments and attitudes towards patients. Journal of Consulting Psychology, 24, 316-323.

Welkowitz, J., Cohen, J., & Ortmeyer, D. (1967). Value system similarity: Investigation of patient-therapist dyads. Journal of Consulting Psychology, 31, 48-55.

Winder, A. E., & Hersho, M. (1955). The effect of social class in the length and type of psychotherapy in a Veteran's Administration Mental Hygiene Clinic. Journal of Clinical Psychology, 11, 77-79.

Wolff, W. (1954). Fact and value in psychotherapy. American Journal of Psychotherapy, 8, 466-486.

Yamamoto, J., James, Q. C., Bloombaum, M., & Hatten, J. (1967). Racial factors in patient selection. American Journal of Psychiatry, 124, 630-636.

APPENDIX A

CASE HISTORIES

INTAKE SUMMARY

Mr. S is a 28-year-old black male. He is presently completing a Masters degree in Computer Science. Mr. S, whose primary language is English, came from the Virgin Islands to attend graduate school. He is single and shares an apartment with three other male students.

Presenting Problems

Mr. S feels that he talks too fast and that generally interferes with his ability to deal with other persons. Talking to familiar others makes him anxious and he stammers or stutters. He also feels compelled to be punctual and precise, and to do things fast. He does "not like to waste time or be idle," worries about small things, and is always planning ahead (i.e., "what to do in the next few hours"). He also reports to become upset to some degree when the outcome of his plans do not meet his expectations. He reports being tense most of the time, although he does not find it difficult to relax if he wants to.

Mental Status

Mr. S's appearance is conservative and neat. His verbal expressions and thought content suggest above average intellectual capacity. His speech, although initially somewhat fragmented with occasional pauses, interjections, or mild stuttering became more fluent and clear as the interview progresses, despite a noticeable accent and a possible slight difficulty in articulating certain words. However, he generally does not answer questions directly, but in a detailed round-about way with some redundancy. His elocutions are ordered and logical.

History of Referring Situation

Mr. S was referred for consultation by a Clinic on campus, where he receives speech therapy. The referral indirectly suggested the possibility of anxiety playing a role in his speech problem, and the possibility of psychotherapy as an adjunct to speech therapy.

Mr. S reports a history of stammering or stuttering since early childhood, and of always talking very fast when "excited." He has always experienced some distress approaching people verbally because the subtle reactions to his communicative style have been perceived by him as negative (i.e., facial expressions of puzzlement or impatience).

Family Background

Mr. S's parents migrated from the Virgin Islands to the United States two years ago. His father, who was a commercial artist, now works as a cook in a restaurant. His mother, 44, previously a housewife, now works as a maid in a nursing home. Mr. S perceives the family's change in status as humiliating and some relatives allegedly "rub it in." However, the family has been able to manage well enough to defray the cost of school support for the two sons, of whom the client is the oldest. The younger brother is finishing a college degree this year. This younger brother is reported to be an achiever and doing well, but some early stuttering is reported for him as well.

Continued on Back →

Psychosocial History

Mr. S reports an unremarkable developmental history, except for the occasional mild stuttering since the age of 6 years. He attended an all-male school from preschool to last year of high school. His performance was "average" because he was too fond of playing; for which he was occasionally punished if school work was neglected. At around the age of 12 years he reportedly began getting serious about school, but does not recall any pressure to do so from external sources. He attended college at an all-male school in the Virgin Islands, after which he migrated to the United States to pursue a graduate degree. A year before graduating his family emigrated to the United States.

Mr. S has had a closer relationship with his mother than with his father. The mother is described as very strict, quite frank, sometimes forceful, quite capable, and as a very nice person. The relationship with the father has been distant, although the client is certain of his father's affection. The father is described as somewhat impersonal, not openly affectionate and indifferent to emotional stimuli.

Mr. S has had limited personal contact with females, mainly some early interaction with cousins. He attributes this to cultural restrictions, but acknowledges being somewhat shy towards women. He has never dated anyone. He has not allowed himself to "get close" to any female, because of cultural restrictions and because he thinks they would not be interested in him anyway. Mr. S has several male acquaintances with whom he partakes of some entertainment, such as the movies and sports.

Current Life Situation

Mr. S has completed the requirements for the Masters degree. He is presently taking some courses and applying for employment. Major sources of stress are the invariably negative responses he has to the considerably large number of applications he submits. However, he is confident something will turn up. Presently, he receives research assistantship stipends, which appear to be well managed. He acknowledges that he could receive financial assistance from his parents, if needed. Mr. S also participates regularly in the events of several local community organizations.

Motivation

Mr. S would like to speak more slowly and to be less apprehensive about talking. He appears to be interested in finding out why people react negatively to his verbal approach in order to improve his chances with his interpersonal relationships.

Diagnostic Hypothesis

Mr. S appears very sensitive to rejection, and to use a polarized structuredness and rationalization as a means to avoid rejections. It is obvious he is fairly distant from his feelings and that basically he may be an insecure individual. Given the long history of stuttering and anxiety related to interpersonal interactions, it is possible he may have rationalized that a speech deficit is the cause of his deficient relationships.

INTAKE SUMMARY

Identification of patient: Mr. W is a 27 year old white male who works as an organizer for a public interest group. He has attended several colleges, but has not received a degree. He is from a middle class family. He currently lives alone.

Presenting symptoms or syndrome: The client stated that feelings of panic and insecurity have begun to overcome him, and that problems from his past are beginning to "catch up" with him. He also described having difficulties with a woman whom he has been seeing. He also reported that he has been driven to move from place to place in the past, whenever things got "complicated," and that he wants to be able to resist this urge in the future and stabilize his life.

Mental status: The client dresses rather casually, often in clothes from second-hand stores, but is always neat in his appearance. There were no indications of thought disorder or severe psychopathology, and the client seemed to be highly intelligent and insightful.

History of Referring Situation: The client reports that he has been "happy-go-lucky" most of his life, but feels that his past is now "catching up" with him. He has not had any previous therapy.

Family Background: W's grandfather was a wealthy businessman, and his family had a middle-class life. Although Mr. W describes his stepfather as "paranoid," and his mother as "depressed and alcoholic" neither were ever hospitalized for psychiatric disorder. His brother is a highly successful administrator and businessman.

Psychological History: Mr. W's father died when the client was 3 years old, and one of his earliest memories is of the plane flight to his father's funeral. He lived with his mother and grandparents until the age of 5, when his mother remarried. Mr. W describes his stepfather as an extremely rigid, paranoid man who made life miserable for the family. He speaks with bitterness of this man who he feels caused most of his current anxieties and self-doubt. He was frequently punished by this step-father for minor offenses in a way he felt was arbitrary and overly severe. Mr. W describes his relationship with his mother as becoming more distant, since his step-father interpreted affection from the mother to the children as indications of "disloyalty."

As an adolescent, Mr. W was an outstanding high school soccer player "but was rebellious and uninterested about academics." His brother was labeled by the family as the "smart one," and Mr. W as the "athletic one."

Mr. W's days in college were marked by frequent incidents of dropping out of school, moving, and beginning at other schools. He met the woman who became his wife while at school. His wife began having affairs with other men, however, and they were divorced after five years of marriage. They have been apart for about ten years. His wife had a son who Mr. W is convinced was fathered by another man.

Continued on Back →

Since the marital breakup, Mr. W has lived with or been in an intensive relationship with a series of women, maintaining monogamy with each for a period of time.

Past Medical History: Mr. W reported feeling a good deal of muscle aches and other psychosomatic signs in the months before beginning therapy. He has been in good health for most of his life.

Current Life Situation: Mr. W has been involved in a struggle about whether to continue his relationship or go on to another woman. He is working as an organizer for a local public interest group, and he currently lives alone. He is friendly with the people he works with, but prefers to spend time with his current love object or by himself. He enjoys running, and other outdoor activities. Mr. W also participates regularly in the events of several local community organizations.

Financial Status: He has a small income from his work and lives quite modestly, having few material possessions.

Motivation: Mr. W seems highly motivated to understand his past. He is also highly motivated to ensure that he does not become overly dependent or involved with me. Thus, keeping him in treatment may be difficult.

Diagnostic Hypotheses: Several issues seem to be especially important to explore. These include Mr. W's avoidance of complex personal involvements, constant need for an intense relationship with a woman, difficulties expressing anger, and feelings of guilt. Exploring the historical roots of these problems, and helping the client to fully appreciate the role of his early experiences in the development of his problems, will be quite important.

APPENDIX B

CLINICAL JUDGMENT SCALE

QUESTIONNAIRE

NOTE: Please fill this out in accordance with your assessment of the client, not that which may be implied by the report.

1. How much anxiety does this patient seem to have?

1	2	3	4	5	6	7
great deal		fair amount		relatively little		very little

2. How much environmental stress does this patient have to contend with?

1	2	3	4	5	6	7
great deal		fair amount		relatively little		very little

3. How much insight do you think this patient has into his problems?

1	2	3	4	5	6	7
great deal		fair amount		relatively little		very little

4. How much motivation for therapy does this patient have?

1	2	3	4	5	6	7
great deal		fair amount		relatively little		very little

5. How would you rate this patient's overall emotional maturity?

1	2	3	4	5	6	7
very adequate		fairly adequate		relatively inadequate		very inadequate

6. How would you characterize this patient's social adjustment?

1	2	3	4	5	6	7
very adequate		fairly adequate		relatively inadequate		very inadequate

7. How much "ego strength" does this patient seem to have?

1	2	3	4	5	6	7
great deal		fair amount		relatively little		very little

8. Considering the entire range of mental disorder, how would you characterize the degree of disturbance in this patient? (check one)

_____ Extremely disturbed
_____ Seriously disturbed
_____ Moderately disturbed
_____ Mildly disturbed
_____ Very mildly disturbed

9. Please give a diagnosis for this patient.

10. If this patient were accepted for psychotherapy, how would you rate the chances of his "acting out" interfering with treatment? (check one)

1	2	3	4	5	6	7
very likely		fairly likely		relatively unlikely		very unlikely

11. How extensive a change in the patient's character structure would you attempt?

1	2	3	4	5	6	7
great deal		fair amount		relatively little		very little

12. Assuming the patient did not terminate prematurely, about how long would you expect to see this patient? (check one)

____ Less than three months
____ From three months to just short of a year
____ From a year to eighteen months
____ From eighteen months to two years
____ From two to three years
____ Longer than three years

13. Assuming that no treatment were undertaken, how would you rate the prognosis for this patient?

1	2	3	4	5	6	7
very favorable		fairly favorable		relatively unfavorable		very unfavorable

14. Assuming that your recommendations for treatment were followed, how would you rate the prognosis for this patient?

1	2	3	4	5	6	7
very favorable		fairly favorable		relatively unfavorable		very unfavorable

15. How would you rate your willingness to accept this patient for treatment?

1	2	3	4	5	6	7
very willing		fairly willing		relatively unwilling		very unwilling

16. Do you find it easy or difficult to empathize with this patient?

1	2	3	4	5	6	7
very easy		fairly easy		relatively difficult		very difficult

17. How would you characterize your personal reaction to this patient?

1	2	3	4	5	6	7
very positive		fairly positive		relatively negative		very negative

18. In a few sentences, what would your therapeutic approach and/or goals be with this patient. If they would be in any way different from your usual way of working, please describe.

19. (optional) In the space provided below, please make any additional comments you wish concerning the patient, your responses, or the task itself.

APPENDIX C

DEMOGRAPHIC AND

IDEOLOGY QUESTIONNAIRE

THERAPIST BACKGROUND INFORMATION

Sex _____ Age ___ Race _____ Religion _____

Family of origin religion _____ City and State now living _____

City and State of origin/_____ (nation if not US)

Theoretical orientation (check one):

Eclectic _____	Psychodynamic _____	Rational-Emotive _____
Interpersonal _____	Psychoanalytic _____	Humanistic _____
Existential _____	Object Relations _____	Behavioral _____
Cognitive-behavioral _____	Other (Specify) _____	

If you have checked eclectic, please circle the orientation which most informs your work.

Political beliefs:

Strongly liberal _____	Moderately conservative _____	None _____
Moderately liberal _____	Strongly conservative _____	Other (specify) _____

Religious beliefs:

Strongly traditional _____	Moderately liberal _____	Agnostic _____
Moderately traditional _____	Strongly liberal _____	Atheist _____

Other (Specify) _____

Socioeconomic background (i.e., family of origin)

Upper upper class _____	upper middle class _____	upper lower class _____
lower upper class _____	lower middle class _____	lower lower class _____

Sexual orientation:

heterosexual _____ homosexual _____ bisexual _____ other _____ (specify)